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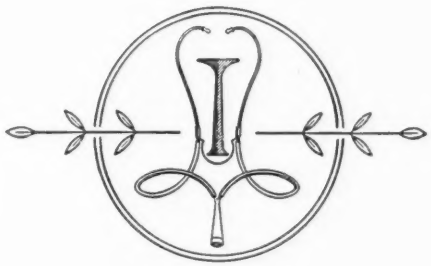

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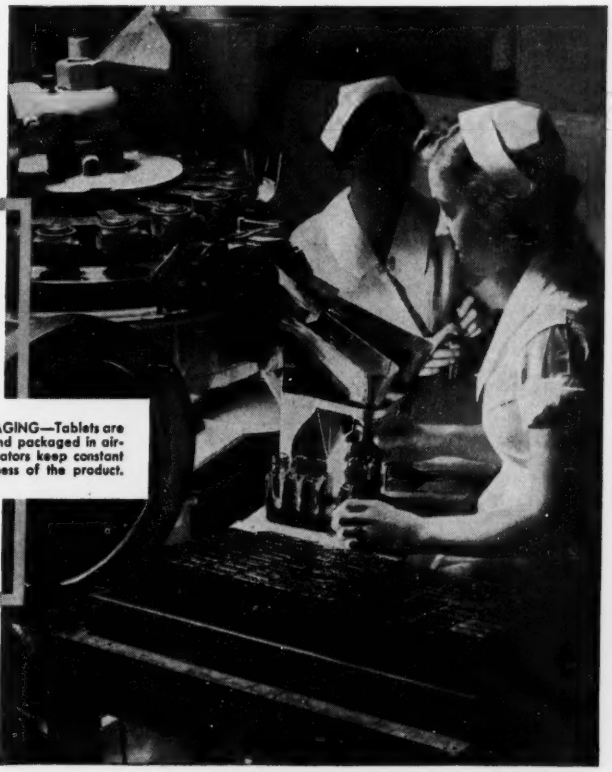

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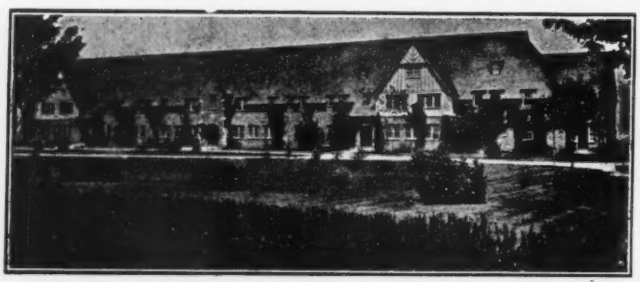

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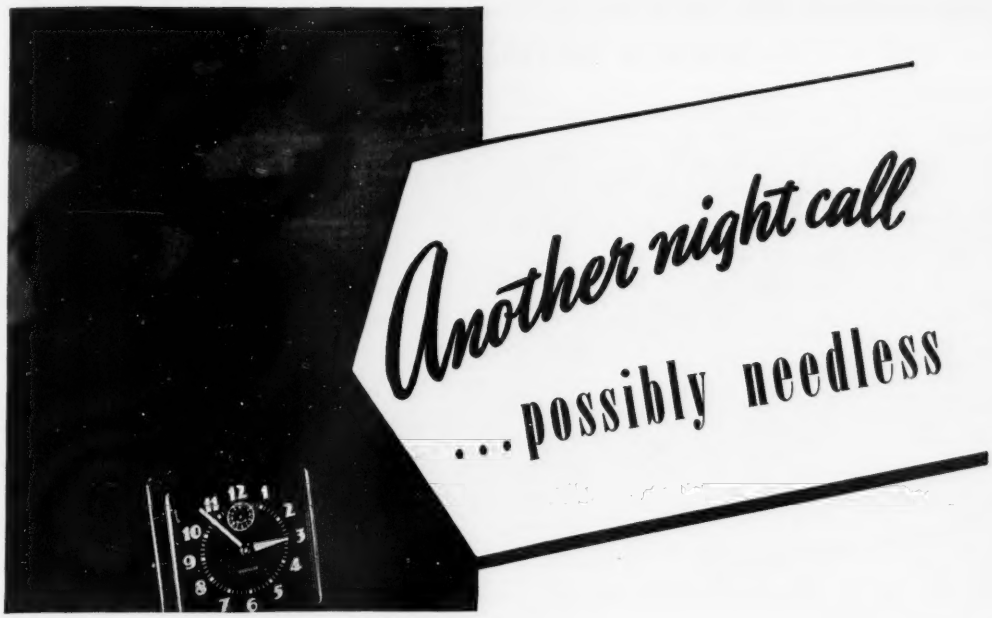

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THE TREATMENT OF CONGESTIVE FAILURE

Julius Jensen, M.D.
St. Louis, Missouri

INTRODUCTION

By congestive failure we understand a disproportion between the strength of the heart and the work it has to do. We think of the heart in a strictly mechanical sense, as a pump which fails to shift the blood from the venous to the arterial side of the circulation. In angina pectoris, another form of heart failure, the heart does not fail as a pump, but signifies by other means its inability to carry on. Furthermore, heart failure need not necessarily mean that the heart has become weaker, unquestionably it many times fails because its load exceeds its normal power. We may compare heart failure with the failure of a team of horses to move a load of rocks. We may then overcome the failure by increasing the tractive power of the horses or by lightening the load or by a combination of the two. Cardiac therapy has made use of all three of these methods, most recently the trend has been to use the third.

REST

Rest is the first and universally accepted principle in the treatment of heart failure. This means complete and absolute rest in the position most comfortable to the patient. Often patients with heart failure are ambulatory and it is hoped that an adequate result may be obtained from digitalis and diuretics. While these measures may be sufficient they often fail, even though the patient be confined to his room. The complete rest offered by a hospital bed, away from the patient's usual surroundings may benefit him more than any other single measure. The cardiac patient, being orthopneic, naturally will insist upon sitting up in bed, and in advanced failure it may be better to place him with his legs dependent and his elbows resting on a firm support so that he may use his auxiliary respiratory muscles. For this purpose a specially constructed cardiac bed is preferable, though satisfactory arrangement can be made by means of chairs and suitable bedside tables.

The rest should be continued as long as the heart shows signs of distress, but not much longer. Once the heart again controls the circulation it should be submitted to some training which will enable it to recover its tone. Prolonged absolute bedrest following heart failure is not advisable except when it is required by some complication, such as active rheumatic carditis.

When a patient with congestive failure is first seen he is frequently so exhausted that he cannot relax. He should then receive morphine in adequate doses: One-fourth grain to begin with and one-sixth to be repeated as often as necessary. By many cardiologists, morphine is considered more important than any other drug used in the treatment of congestive failure. When the patient has had one or two nights of sleep through the aid of morphine, milder sedatives of the barbiturate or bromide group may be substituted.

WATERBALANCE

While heart failure is characterized by the retention of fluid in the tissues it is not associated with hydremia. Water is driven into the tissues by the increased hydrostatic pressure in the peripheral circulation and this process is accentuated because the capillaries are damaged by anoxemia. With twenty to thirty additional pounds of water in the body it is desirable to establish a negative water balance. Consequently, fluids should be limited to 800-1200 cc. daily, depending on the surrounding temperature and the patient's weight. The best control of the water balance is not the measurement of intake and output; the urine output is difficult to determine in many sick patients, and it does not take into consideration fluid lost through the lungs, bowels or skin. Regular weighing of the patient is a much surer guide on gain or loss of fluid and should be done whenever possible. If cardiac patients are regularly weighed, retention of fluid may thus be discovered earlier than by looking for manifest edema. The discharge of fluid is best obtained by the combined use of cardiac and renal stimulation.

Venesection has a distinct but limited place: In acute pulmonary edema and in general congestive failure with marked cyanosis and pulmonary congestion, acute distress is often markedly relieved by

the removal of 3-700 cc. of blood. But because the blood itself is not waterlogged, venesection cannot find general application in the treatment of congestive failure.

DIGITALIS

Of the drugs specifically used in cardiac therapy, digitalis enjoys by far the greatest popularity in this country. There is not as yet absolute agreement on its mode of action in congestive failure. We know that it lessens the conductivity of the auriculo-ventricular bundle, thus, if given in adequate doses to a patient with auricular fibrillation it will prevent the feebler impulses from reaching the ventricles: Thus the ventricles will be rested and respond better to the more powerful impulses and the general circulation will be improved. This action is best seen in heart failure from mitral stenosis with auricular fibrillation. There is also good evidence that digitalis acts directly on the heart muscle, and increasing evidence that this effect is of value in the treatment of congestive failure. Thus is explained the beneficial effects of digitalis on congestive failure when the rhythm is regular. British authors, referring to Mackenzie's teaching, place the greater emphasis on the effect on the auriculo-ventricular conduction in auricular fibrillation. American authors as a whole consider the effect on the myocardium more important. In his latest paper, Parkinson finds that the effect of digitalis on heart failure is most marked in the presence of auricular fibrillation.

Digitalis does not directly slow the heart rate when given in therapeutic doses. Any slowing of the regular heart in congestive heart failure treated with digitalis will be caused by the general improvement in the patient's condition rather than by a direct effect on the sinus node. Excessive slowing of the heart may result from a toxic effect on the sinus node, bigeminal pulse with very faint extra beats, or finally, but rarely, from heart block. Digitalis has no effect on the sinus node in sinus tachycardia from causes other than congestive failure, unless it be given in toxic doses.

Digitalis has no diuretic effect except indirectly through its action on the heart.

Some years ago other drugs with a digitalis-like action occupied a prominent place in the pharmacopea, best remembered are squill, strophanthin and ouabain. The two last named are still much used respectively in Germany and France. Recently two other substitutes have been offered in this country—thevetin and urginin. There is no evidence that any of these drugs has an effect superior to that of digitalis when this drug is given in adequate amounts. They do, however, have a place, when the patient shows marked intolerance to digitalis.

For many years the tincture was the favorite preparation of digitalis but within the present decade the powdered leaf has become almost universally accepted in cardiac clinics. Once standardized it retains its strength indefinitely and the dosage can be more accurately measured than with the tincture. Of the various preparations of powdered leaf none is of proven superiority, any preparation backed by a reliable drug house may be used.

Opinions vary as to the degree of failure requiring the use of digitalis. All agree that it should be used when edema is manifest but this is a relatively late symptom of heart failure. In my opinion increasing dyspnea on effort, increase in heart rate, rales at the bases of the lungs, a persistent cough or insomnia from pulmonary congestion are indications for energetic digitalis therapy. When the patient is seen in early failure, digitalization may be slow; .1 gram of the powdered leaf three times a day may be enough; but when heart failure is advanced the administration of digitalis should be faster.

About twenty years ago Eggleston showed that the optimal amount of digitalis which could safely be given in congestive failure is much larger than was formerly believed. He then suggested a rapid method of complete digitalization, the amount of digitalis being calculated according to the patient's weight. The Eggleston method has generally resulted in the adoption of much larger doses of digitalis than were formerly used. However, many clinicians hesitate to give the full doses recommended by Eggleston, for it is often difficult to make sure that the patients have not already received some digitalis, and once the drug is absorbed there is no way of neutralizing its toxic effects. Both the toxic and the therapeutic response to the drug vary with the individual. Some persons are hypersensitive to the drug and in them the full Eggleston dose would be dangerous. Finally, the very large doses of digitalis are unnecessary for almost every patient with congestive failure will recover just as well if digitalization is extended over a few days.

Patients with congestive failure who presumably have received no digitalis recently, may be digitalized as follows: Within the first twenty-four hours the patient receives .3 grams of the powdered leaf three times. During the second twenty-four hours he receives .2 grams three times; a total of 1.5 grams over forty-eight hours, or approximately two-thirds of the full Eggleston dose. Further administration of the drug will depend on the patient's response. .2 grams may be given three times a day the following day, or the dose may be reduced to .1 gram. Thereafter, the dose should be continued at .1 gram three times a day and diminished as indicated.

Digitalis treatment aims at the optimal rather than the maximal therapeutic effect. Therefore, the dose should be reduced as soon as the benefits are obtained; even the earliest toxic signs indicate error in treatment.

When compensation is restored, the amount of digitalis must be determined which will maintain it. This, the maintenance dose, should equal the rate of excretion, but this function varies with the individual and the amount of digitalis stored in the body. Usually it is between .1 and .2 grams daily. As it cannot be calculated it must be determined empirically through gradual reduction of the dose, while the patient is being closely watched for the earliest signs of cardiac distress.

The early toxic signs are the appearance or increase in number of extrasystoles progressing to coupling if the drug is not stopped, loss of appetite, nausea and vomiting and marked slowing of the heart rate. Less common signs are xantopia and auricular fibrillation. The electrocardiographic signs are important, especially changes in the T waves which become flattened or even inverted. There has been some discussion regarding the leads most likely to be affected by digitalis. I believe overdigitalization is more likely to render manifest latent changes in any leads rather than regularly to affect a particular lead. Many of the changes may last for a week or more after the drug has been discontinued.

In congestive failure it is rarely necessary to give digitalis parenterally. If the patient vomits the drug because of gastric irritability, repeated administration may be more successful. If vomiting persists, digitalis is well absorbed in a starch enema. More prompt effects follow parenteral methods of administration but intramuscular injections are painful and intravenous injections have had serious consequences.

DIURETICS

The only certain effect of digitalis, then, is to strengthen the heart action. It is, therefore, well to support this drug with others which will relieve the load on the circulation; that is, diuretics. Simplest of these is the limitation of salt. The manner in which sodium ions aid fluid retention is obscure, but it is well known that limitation in their intake is followed by increase in excretion of fluid. I do not believe it is necessary to carry salt restriction beyond omission of salt at the table and avoidance of salty dishes.

Of somewhat greater importance is the use of ammonium chloride which acts by producing acidosis. The exact mechanisms is not clear, but it seems to lessen the amount of salts absorbed into the tissues, and thus increase the osmotic pressure of the blood. As ammonium chloride is absorbed, the ammonium is converted into urea, the diuretic effect depends entirely upon the liberated acid radical. Ammonium chloride should be given in sufficient doses—e.g., three gram three times a day. The one important contraindication is renal insufficiency.

In itself ammonium chloride is a rather feeble diuretic, and it is generally used in combination with mercurial diuretics. The effect of these is enhanced by the acidosis which it produces, thus the two drugs act synergistically.

Until quite recently, drugs of the theophylline group were extensively used as diuretics in congestive failure. They act on the glomeruli by increasing filtration. They are, however, not as effective as the mercurials, and their action soon wears off on continuous use. Consequently, they are rapidly yielding to mercurial diuretics which, then are the diuretics of choice in congestive failure.

The mercurials are contraindicated only in severe renal insufficiency (i.e. with N.P.N. above seventy-five mgm. per 100 cc) when they may cause complete suppression of urine. In this connection it must be remembered that in congestive failure the urinary findings may closely resemble those of nephritis without being a contraindication to mercurial diuretics. The older preparations not infrequently produced mercurialism, but this rarely follows the modern drugs. The diuretic effect of this group is very powerful, they act directly on the kidneys, by suppressing tubular reabsorption.

For the last decade salyrgan has held the field; it is efficacious and safe and presents only two drawbacks, it can only be given intravenously and extravasations produce very painful and often suppurative lesions. If the veins are difficult to reach salyrgan administration presents a serious problem. The fear of renal suppression and mercurialism, however, is perhaps somewhat exaggerated.

Within the last few years mercupurin has become a powerful rival of salyrgan. It contains a radical very similar to salyrgan, and also theophylline. Thus, theoretically at least, it combines the effects of the xanthines with that of the mercurials, increased glomerular filtration with decreased tubular absorption, and, in fact, it has proven more potent than salyrgan on direct comparison. It has the additional advantage that it can be given in rectal suppositories; unless irritation or ulceration be already present, it has no local effects. This is a marked advantage over salyrgan suppositories which may be very irritating. If, on intravenous administration, some of the drug should escape into the subcutaneous tissues, the local effects are not nearly as severe as after

salyrgan. Salyrgan and mercupurin contain about the same amount of mercury.

In many cases of sudden severe heart failure, especially if associated with pulmonary edema, hypertonic glucose injected intravenously may be useful. The usual amount is 100 cc of fifty per cent solution. This drug has a twofold value—it will increase the osmotic pressure of the plasma and thus help the return of fluid from the tissues and, being readily metabolized, it is valuable nutriment for the failing heart muscle, which, in addition to its hemodynamic handicap, may itself be malnourished from poor circulation. The effect of glucose in these conditions may be dramatic.

OXYGEN

In advanced heart failure cyanosis may be marked. In such cases oxygen should be administered in adequate quantities. The various tents are now rapidly yielding to the nasal catheter which is simpler to use and much cheaper as it consumes less oxygen.

INFECTIONS

Finally, to complete the discussion, the part played by infections in precipitating heart failure should be considered. The treatment of congestive failure is greatly influenced by its immediate cause, and if this can be removed, the recovery may be facilitated. Respiratory infections are here most important: Sinus infections, bronchitis and pneumonia should all be energetically treated. In fact, pulmonary congestion, pulmonary edema and pulmonary infection often interlace and so form a vicious circle that separate treatment of the various factors is impossible. The advances in the treatment of respiratory infections, including pneumonia, may well include improvement in treatment of congestive failure.

PROGNOSIS

There are many ways of gauging the effect of treatment. In the early stages the weight curve is most valuable and as edema is a most important part of congestive failure the advance or retrogression thereof will naturally be of most immediate value in evaluating the patient's progress. The pulse rate or apex rate are also useful though they must be studied with due consideration to other factors which may affect them. In auricular fibrillation in arteriosclerotic heart disease a slow ventricular rate may be due to arteriosclerotic auriculoventricular block, and following digitalis, the rate may be slowed while edema still persists. Such patients particularly need diuretics in addition to digitalis, and they, furthermore, have a poorer prognosis than those who can be controlled with digitalis. So, while the heart rate is a most valuable guide in estimating the degree of improvement and prognosis in congestive failure, it must be observed with due regard to the entire clinical picture.

The blood pressure is of little value in estimating progress of congestive failure for it behaves according to no set rule. Often the pulse pressure is low, but the diastolic pressure is not a good guide to the degree of edema. The arterial pressure sometimes falls in heart failure, but it may remain high; in hypertension even very high. This observation is important for it must mean that heart failure is not always caused by loss of myocardial strength, but rather by a disproportion between this factor and cardiac work. In fact, sometimes, the blood pressure is higher during decompensation than later when compensation is restored. The blood pressure, therefore, is too irregular in its behavior to indicate the effects of treatment on heart failure.

As dyspnea and orthopnea are signs of myocardial embarrassment, so their diminution or disappearance are signs of recovery. Probably this sign is most accurate and parallels most closely the course of congestive failure. Closely related to the study of dyspnea is that of vital capacity, in fact the two are so closely associated, that little additional information is obtained from detailed studies of the latter.

Also the circulation time of the blood has been studied in relation to congestive failure, it is slowed, roughly, in proportion to the severity of the failure. While the determination of the circulation rate is relatively simple, it has not been found to yield enough information to compensate for the extra trouble of performing the test.

Finally, venous pressures have recently been measured directly by very simple technique. The usefulness of the test is proven by its increasing application. It is difficult to conceive of congestive failure without increase of the venous pressure, and probably it forms the most delicate method of measuring the change in degree of congestion. Its greatest value, however, continues to be in differential diagnosis.

To sum up, the effect of treatment on congestive failure is best observed by changes in respiration, by disappearance of edema with corresponding decrease in weight, by return of the heart rate to a normal level, and by special diagnostic procedures, of which venous pressure probably is the most delicate.

The benefits to be expected from the treatment of congestive failure have not been exactly determined. Heart failure is a progressive condition which in spite of all treatment will claim the greater part of sufferers from heart disease. The extent to which treatment will increase life expectancy has, I believe, not been proven. Insofar as congestive

failure is precipitated by transient accessory factors, such as infection or overwork, as is often the case in rheumatic or degenerative heart disease, efficient treatment may be of real value, but when the failure is caused by a progressive destructive process, the cause of which is practically unalterable, as in advanced syphilitic heart disease, treatment can hardly be expected to do more than ameliorate symptoms.

On the other hand, energetic treatment may be of very definite value in delaying the advancing process, especially during the early stages, and ameliorating its course when it becomes more advanced. By treating colds energetically, by regular supervision of cardiac patients and by thorough treatment of the earliest signs of congestive failure much suffering may be prevented. In fact, many clinicians believe that less congestive failure is seen in hospitals now than formerly.

THYROIDECTOMY

Finally, a word should be said about total thyroidectomy for congestive heart failure. This procedure which caused so much discussion some years ago has now almost disappeared. It is true that most times the operation was a partial or total failure, but sometimes the benefits were really striking. Even taking into consideration the spontaneous changes which sometimes occur in congestive failure, I believe that some of our patients were markedly benefited and that the procedure continues to have a definite, though very limited, place in the treatment of congestive heart failure. Thyroidectomy is indicated where heart failure progresses very slowly and fails to respond to the best possible medical treatment. A long pre-operative period of observation is necessary. The presence of very unfavorable changes, such as bundle branch block, form contraindications. It is, furthermore, possible that some of the patients who benefited most from the operation were really suffering from occult or latent hyperthyroidism; this, however, is a much disputed point, which in itself does not affect the value of the procedure.

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300 X-ray Examinations per Hour—A new method of x-raying the chests of large groups cheaply and quickly has been developed in Germany. It consists of photographing the fluoroscopic image on motion picture film. When developed, the strip of film is projected on a screen for interpretation. By this method two physicians, assisted by a crew of 10 men, examined at the rate of 300 per hour, more than 10,000 men during a Nazi party celebration at Nüremberg. The device is not a substitute for the standard x-ray technique but is a means of "screening" and it promises the possibility of examining the whole nation. Holfelder, H. and Berner, F., Muenchen. Med. Wchnschr. 1938, 47.

IDENTIFICATION AND HANDLING OF THE ALLERGIC NOSE*

L. Weston Oaks, M.D.
and
Wilmer L. Allen, M.D.
Provo, Utah

Nowhere in the field of medical diagnosis is it more important to look at the patient as a whole than when dealing with a nasal problem which may turn out to be allergic. However disinclined one feels toward doing this, there is no successful short-cut substitute. Perhaps there are some intranasal situations which can be diagnosed accurately by looking into the nose, with the rest of the face and body covered, but allergic disturbance is not one of them.

If anything relating to this condition has been established the general nature of its influence must be that thing. Hence, when one is faced with a doubtful combination of local signs and symptoms one must turn elsewhere for aid to their identification. Reaching a decision as to whether allergy is in some degree responsible for given clinical manifestations will often not, even then, be easy.

In January of 1937, one of us (Oaks) published an outline of a physiologic hypothesis or explanation of allergy, based upon ten years of clinical study, and upon a correlation of newer material in physiology. In this application, facts already established appear logically to suggest deduction of other possible facts to fit into the picture. Its simplicity and workability, together with an increased percentage of good results, have been a source of some satisfaction, although some of its important phases are not yet sufficiently clear to assure unfailing success.

Time limitation must confine our discussion of theory to the barest essentials, offered by way of explanation, paving the way for practical application to every day problems. More detailed description and bibliography may be found in the original publication.[1]

The fundamental concept to be kept in mind is that allergic predisposition is a definite pattern in physiology. This pattern is undoubtedly formulated in the individual, or hereditary, arrangement of relationships between endocrines and sympathetico-parasympathetic balance.

Sympathetic and parasympathetic divisions of the autonomic nervous system are normally maintained

*Read before Pacific Coast Oto-Ophthalmological Society, June 1938.

in a state of balance, or working adjustment between the opposing forces they represent. In other words, katabolic energy of the sympathetic must be properly regulated by anabolic activity of the parasympathetic. This state of balance is profoundly influenced by glands of internal secretion, both in embryonal development and during the postnatal life. From stimulation of sympathetic nerves a chemical substance called sympathin is produced, while agitation of parasympathetic furnishes a counteracting chemical called parasympathin, or iriginally "vagus substance."[2]

Should sympathetic action be kept in excess of the opposing parasympathetic there results a combination giving high blood pressure, rapid pulse, restlessness, hyperthyroidism, high acid elimination, body temperature at full normal and readily increased, tendency to colds and other respiratory infections, red and active nasal mucous membranes, and sensitiveness to heat. Reversal of the relationship to allow abnormal domination of anabolic factors brings an opposite picture with: Low blood pressure, slow pulse, morning fatigue, hypothyroidism, low acid elimination, subnormal body temperature, relative freedom from infective colds, sensitiveness to cold. Along with this, pallid, wet, sluggish intranasal membranes, which easily become polypoid, are frequently found.

These latter features are characteristic of the allergic individual; and when supported by a history of hay fever, bronchial asthma, food sensitivity, morning sneezing, dermatological phenomena suggesting allergy, migraine, vernal conjunctivitis, or other recognizable evidence of this disease, are not to be mistaken.

Should the above hypothesis prove correct, it naturally follows that any person having a sympathetic combination of factors cannot possibly be allergic. If true, this immediately gives us an important practical advantage in the study of any individual problem. While it is a fact that we have sometimes found difficulty in analyzing combinations which appeared to partake of both sets of factors, they have usually proved to be definitely one or the other, or not due to any demonstrable imbalance in this field.

Careful inquiry into the history yields much useful information. There seems no doubt that allergic susceptibility is familial, just as endocrine disorders are familial, and one should ascertain the presence of such troubles among other members of a patient's family. The person with marked degree of allergy rarely has infective colds, although frequent coryza of allergic origin may be mistaken for them. Morning sneezing, while it does arise from other causes, strongly suggests allergic inclination. Post-nasal drainage may or may not be present, and may or may not be purulent. Appetite for food is not characteristic, but the frequency of acid stomach, heartburn, or hyperacidity with some flatus is striking. Not uncommonly the patient will be certain he has gastric ulcer, because of severity of symptoms. He may even have had such a diagnosis. In the majority of cases constipation in some degree is present.

Character of sleep varies from deep slumber to moderate insomnia occurring in the latter part of the night. Inquiry will almost certainly elicit complaint of mild or severe morning fatigue, which occurs irrespective of how the individual sleeps. This may be present only when the disease is active and causing symptoms, or it may be a constant thing in a patient who has but mild local manifestations. Sensitiveness to cold is usually admitted, but there may even be mild sensibility to heat instead.

Association between foods, dusts, plants, or other environmental factors, and onset or accentuation of the trouble is of great significance and must not be overlooked. This is unlikely to be discovered in non-allergic persons, although some are subject to poisoning by certain foods and drugs, even in small amounts, irrespective of any demonstrable allergic tendency.

Nasal mucous membranes generally exhibit more or less pallor. In severe cases this is marked and is coupled with wet, sluggish thickening of submucosal tissues, leading to formation of polypi. Where the diagnosis is difficult, as in borderline cases, this is often lacking, and a comparatively red membrane may be found in one frankly allergic.

Cytology of nasal secretions is helpful. During inactive periods of the disease, one is likely to find a mixed cytology with no eosinophiles present. When acute seizures are on, eosinophiles in varying numbers will be found in most cases. Associated with this there is often an increase of eosinophiles in the blood. Their number may be anywhere from two to twenty per cent of total leucocytes.

Systolic blood pressure is somewhat lower than the usual normal. Our observations bear out consistently Blackmar's statement[3] that high blood pressure in an individual with recognized allergy indicates disease of the vascular-renal apparatus. Pulse rate and body temperature, if unmodified by any unusual influence, will be somewhat subnormal as a rule.

We have given up use of skin tests because we feel that, besides being a trial to both patient and physician, they are not justified by dependability of the information they furnish.

Titration of urine acidity gives some additional

help. For this purpose we obtain three morning specimens, and insist that if possible they be in the laboratory within two hours after they are collected. We do not require their being taken on consecutive days unless it is convenient, but we do require that each specimen be collected before any food or drink is taken in the morning. Two per cent alcoholic solution of phenolphthalein is used as indicator, and titration is done with N/10 sodium hydroxide. The allergic person commonly shows a total acidity requiring 0.5 cc. to 1.4 cc. of N/10 sodium hydroxide to neutralize five cc. of urine. Those not allergic will generally run from two to five cc. or more. Specific gravity of the urine is also likely to be lower than usual, running between 1.008 and 1.016.

As a rule, analysis of material resulting from study along these lines will readily classify a patient as allergic or non-allergic. In mild or obscure cases, adoption of a test program of therapy may be necessary to try out one's conclusions. A few weeks will usually settle the question and clear up the diagnosis.

In the handling of allergy, purely local treatment really accomplishes little. General measures will give definite help, and in many will be all that is necessary. Where conditions such as septal deviations or marked hyperplasia are present, combination of local and general treatments is imperative. It appears, however, that surgery except for removal of obstructing polypi, is better delayed until general treatment has reduced edematosis of soft tissues. Often borderline surgery will not then actually be required.

In the dietary, avoiding too heavy use of alkalinizing foods is important. Also these individuals are frequently found to be taking too little of animal proteins. One should urge the increased use of table salt, since allergic patients are invariably low in chlorides. Avoidance of citrous fruits of any kind in any form is to be insisted upon, and in severe cases, tomatoes and tomato juice should be left out. This appears to be of utmost importance. Experience has taught us that these foods are definitely poisonous to allergic patients. Not infrequently one sees a person suffering severely in whom relief is quickly given by this one measure alone.

In medical treatment, one has recourse to three classes of preparations in particular: endocrines, sympathin, and stimulants to the sympathetic system. Among endocrines, thyroid has proved of greatest help so far. Tolerance for this drug, in those with severe allergy, is often high. In its use we try to bring the dose gradually up to the point of tolerance, as shown by increase of pulse rate and restlessness. Occasionally a patient will develop some swelling of ankles before other symptoms appear, upon which thyroid had best be reduced and chemical stimulants of the sympathetic system resorted to.

Among these benzedrine (Beta-Amino-propyl-benzene) promised much, and is decidedly useful at times. It appears to possess a faculty of augmenting that phase of thyroid action desired. It is tolerated much better by the parasympathicotonic or allergic person than by others. However, the drug must be used with caution even there. We see occasional allergic patients whose noses are kept running and stuffy by their frequent application of the benzedrine inhaler. Yet there are many times when a single use of such an instrument will rapidly terminate an annoying cough of sudden onset, sneezing, posterior nasal drip, etc. that has come up from some allergic alteration in body physiology.

Use of benzedrine internally is more satisfactory as a rule than by any such avenue as inhalation, but the patient should be carefully observed when starting its use, and dosage must be regulated according to individual responses.

With both thyroid and benzedrine, we begin at small dosage and increase to the point of desired effect. Of benzedrine sulphate five milligrams are given before a patient arises in the morning. If more is needed, one dose is given in the early afternoon. Then both may be increased in size if necessary. The benzedrine inhaler is a boon to many a patient in whose problem nasal stuffiness constitutes a prominent and troublesome feature. It appears to act both locally and generally.

Sympathin, which has not yet, so far as we know, been chemically identified, is in our work represented by histidine. This substance appears to fit well into the picture, so far as its clinical effects are concerned. Histidine is also interesting in the response it often arouses. Violent asthmatic seizures have been relieved by it in a few minutes, when repeated injections of adrenalin chloride had failed to show any appreciable effect. It is given as four per cent solution of histidine monohydrochloride in 5 cc. doses, subcutaneously or intramuscularly. Frequency of administration depends upon the individual need. We have given it daily, which appears to be more than even the most violent case requires. Usually two or three doses each week suffice. It is given less often, and finally discontinued as symptoms abate—to be resumed if needed. Often mild cases will not require its use.

Dilute hydrochloric acid by mouth with meals is valuable in many patients. Whether it should be given or not is pretty well indicated by the urine acid titration. Any patient showing a titration of less than one cc. N/10 sodium hydroxide for five cc. urine, in a series titration, is likely to do better on

moderate to large doses of the acid. Occurrence of any burning discomfort after taking it should be considered as indicative of need for reducing the dose or discontinuing it.

Perhaps we should stress the fact that one cannot be certain of striking correct individual dosage of these substances at the start. Every patient should be under reasonably frequent observation for adjustment of the various factors to fit his particular requirements, as brought out by trial. When a suitable program of dosage and frequency has been arrived at, periods between visits may be lengthened.

Cessation of symptoms does not mean that the patient may disregard what has been set up for him. He should be impressed with the importance of following out for a long time instructions laid down. To succeed in this appears to be one most difficult problem in treatment of these people. Use of thyroid, histidine, benzedrine, etc., will eventually become necessary only upon rare occasions for most patients. As a rule, it seems to require one, two, or even three years to establish a better adjustment between sympathetic and parasympathetic systems so there is no marked tendency to recurrence. After that has been accomplished, evident allergy will have become largely a thing of the past for that person, unless some profound disturbance of physiology should upset his balance.

Education of a patient to some understanding of the reason for his trouble is of advantage in gaining his continued co-operation to keep the trouble in abeyance until it has been overcome.

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Why we "see stars" when we are struck on the head is explained by Richard F. Trump, Keokuk, Iowa, in the June issue of Hygeia, The Health Magazine.

"The optic nerve, like all others, carries only one kind of sensation," Mr. Trump says. "Whenever the optic nerve is stimulated in any way—by electricity, by touching or by light waves—we have the sensation of vision. When you are struck on the head, the optic nerves or the visual centers of the brain are stimulated so that you 'see' the bright flashes which you call stars.

A good soap substitute, if the baby has sensitive skin, is a pound of oatmeal or a quart of bran, tied securely in a gauze bag and allowed to soak in the bath water.—Hygeia.

A NEW SEMI-OPEN METHOD FOR REDUCING AND HOLDING SOME FRACTURES

W. A. Heap, M.D.

Mulvane, Kansas

Since some fractures require open operation with the placement of bands, plates and screws, or pins in order to reduce the fracture properly, together with a secondary operation for the removal of the foreign material after union has taken place, a new method which eliminates the necessity of opening through to some of these fractures for the placement of the above mentioned material is explained and shown in this article. For want of a better name, I call it a semi-open method. It is not an open method in the generally accepted meaning of the word open, neither is it a closed method in the generally accepted meaning of the word closed.

DESCRIPTION OF THE INSTRUMENTS

The set of instruments used in this method consists of a pair of universal drilling handles, drills, universal tie-blocks, and standard gauge steel rod. (Figure 1 A shows a pair of drills, handles, tie-blocks and tie-rods.)

Each handle has a triangular opening through its center, which fits the universal shanks of all the various size drills, with a threaded screw in the end which locks the handle to the drill shank.

The drills, per se, are made of stainless steel in order to more readily resist the action of the body chemicals. All the drills except two are paired and graduated in size from one-sixteenth of an inch in diameter for the smaller bones, as the metacarpal, metatarsal and phalanges, up to one-fourth of an inch for the femur. The drill shanks have a universal triangular end which fits into the triangular opening in the handle. Threads run up far enough on the opposite end of the shaft of the drill to allow drilling through the bone, thus threading into the cortex of the bone on each circumference, or 180 degrees from entrance to exit. The drilling end of the drill is so designed that it drills and threads at the same time. In addition, it has a pair of grooves spiraling from the drilling tip up the shaft a short distance; the edges of which have to do with the cutting and drilling. These grooves have a further function in that they pocket detritus bone material as it is cut loose in the drilling operation. (Figure 1 B shows a magnified view of the drilling tip.) Some of the drills have a small shoulder at the junction of the upper end of the threads and the shaft. These are

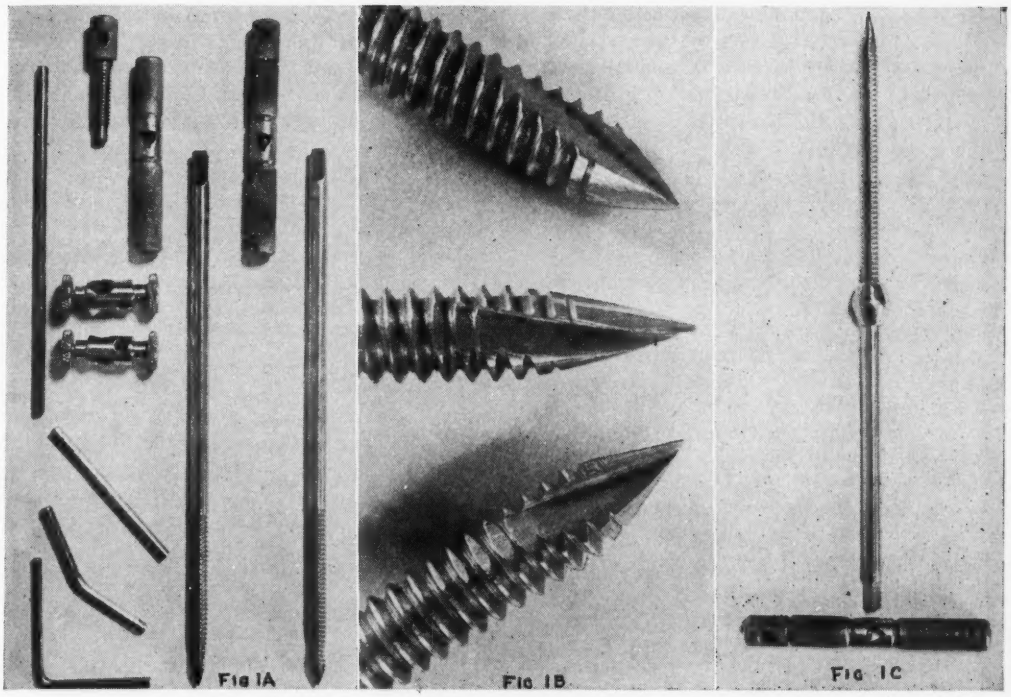


Fig 1A Fig 1B Fig 1C

special drills which are used on such fractures as spiral fractures, where there is a separation of the fragments longitudinally with the bone and one wishes to draw the fragments in snug apposition; or, in case of a fracture of the anatomical neck where one wishes to impact the fracture as illustrated later on. (Figure 1 C shows a drill with shoulder.)

The tie-blocks have two holes through them; one for receiving the shaft of the drill, and the other set at a ninety degree angle to receive the steel rods. At each end of a tie-block is a set screw which locks the shaft of the drill and the steel tie-rod tightly and solidly together in a unit.

The steel tie-rods are 3/32 of an inch and 1/8 of an inch standard gauge steel welding rod. This steel rod is cheap, easily obtained and shaped with a pair of pliers in case the receiving holes in the tie-blocks are not in the same longitudinal plane. It is also sufficiently rigid to withstand the most powerful muscle pull.

METHOD OF USE

The patient is placed under fluoroscopy. After the instruments have been sterilized and the field of operation prepared, the region is placed under local anesthesia, exactly as when one is preparing to insert the Steinman pin or Kirschner wire. A small incision not over .5 cm. in length is now made, barely through the skin, at a point that will place the drill point sufficiently far from the distal or proximal end of the fracture to allow a firm hold in the cortex for the threaded portion of the drill. Take, for instance, a transverse fracture of the surgical neck of the humerus. (See Figure 1.) The point of the drill should enter the bone about 2.5 cm. back on the shaft from the fracture (in the smaller bones, allow less distance from the site of fracture.) The operator now takes the proper size drill, with handle attached, and inserts the point of the drill into the incision and with a movement as in pronation and supination of the wrist and forearm, he forces the drill down to the bone. It is important not to go in with a complete circular movement, as fascia and muscle will roll up around the drill. When the operator reaches the bone with the drill tip, he holds the drill at a right angle to the bone and begins a rotary drilling movement and drills and threads into the cortex of the bone until the tip of the drill is out on the opposite side of the bone. (See Figure 2.) The operator now places the other drill in the other end of the bone in like manner. (See Figure 3.) He now has a firm threaded hold on the end of each fragment. At this point, before any reduction is attempted, the handles of the two drills are removed and two tie-blocks are slipped on each drill shank and allowed to drop down against

the skin; consequently, they are out of the way during manipulation. The handles are now replaced on the drills. The operator clasps them firmly, and by manipulation, he brings the ends of the bone end to end. (See Figure 4.) He now forces the bone back in line; the part in the meantime is properly supported and receives traction, if necessary, by an assistant. The operator continues to hold the bone in line while the assistant brings the tie-blocks up on the shafts of the drills and locks them in place. After the blocks are locked in place, steel tie-rods are shaped for angulation, if necessary, and slipped through their respective holes in the blocks on the two drills and they, also, are locked in position. (See Figure 5.)

The operator now removes the handles of the drills and applies a cast or splint, as his judgment dictates. A small cork may be incorporated in the cast near the drills for use as a fenestra for observation of the skin wound if the operator so desires. After the cast or splint has been applied, the operator loosens the tie-blocks in order to see if the cast or splint will hold the fragments in alignment. If so, the operator removes the blocks and the tie-rods from the shafts of the drills, again places the handles on the drills, unscrews them from the bone, and withdraws them from the soft parts. If the angle of fracture or muscle pull is such that the cast or splint will not hold the fracture in line after the tie-blocks have been loosened, the operator readjusts his alignment, tightens the tie-blocks, tightens the tie-rods, and leaves the drills in place until he has secured a union. Then he removes the blocks and rods, unscrews the drills, and removes them from the part.

In case the fracture is the type that has a tendency to rotate, as some transverse and oblique fractures do, after the drills have been inserted and locked in position, the operator should hold the fragments in alignment while his assistant applies a cast and incorporates the drills in the cast. This will positively stop any tendency to rotate.

METHOD OF USE OF THE UNPAIRED DRILLS

The two unpaired drills are of the larger sizes, and they thread farther up on the shaft than the larger paired drills. They are used to impact and hold fractures of the anatomical neck of the femur and humerus. After a leg or arm has been manipulated until the fragments are in line, the extremity is held in position by the assistant. Then the drill is inserted in the same manner as described previously, the drill is inserted at the proper angle down through the neck, until the drilling end passes through the threads into the dense mass of trabeculae at the junction of the head and neck and the shoulder on the drill at the outer end of the threads is firmly against the cortex where the drilling tip entered about 1.5 cm. below the vasternus line, in the middle of the outer aspect of the femur. Since the junction of the head and neck receives some of the greatest stress and strain in the femur or humerus, the denseness of the trabeculae at that point is almost as solid as the cortex. Consequently, the drill threads are imbedded in dense bone at that point, as well as in the cortex below the vasternus line of the femur and below the tuberosity of the humerus. By further turning of the drill, the shoulder at the cortex prevents the drill from entering further into the bone. But, the continued turning of the drill draws the fragments closely together or impacts them. In other words, it has the same effect as if you were tightening the nut on a bolt. (See Figure 6.)

This applies to the type of case that comes to us in industry as most of our men are comparatively young, strong, rugged and well knit together. I do not believe this method of impacting and holding a fracture of the femoral neck would work at all in the aged where the femur is nothing much more than a hollow shell. I would not advise its use in such a case.

DISLOCATIONS

Whether or not these large drills could be inserted into the femur or humerus the same as in neck fractures and used for traction on the head in a case where the dislocation could not be reduced by ordinary manipulation, I cannot say, as I have never had occasion to use one for that purpose. However, one should be able to get a tremendous lateral pull on a head with such a drill threaded as it is into the bone.

Figure 7 shows a typical fracture of the radius and ulna at the junction of the upper and middle one-third. Figure 8 shows how this type of fracture is reduced and held. Figure 9 shows a longitudinal fracture of the lower end of the humerus.

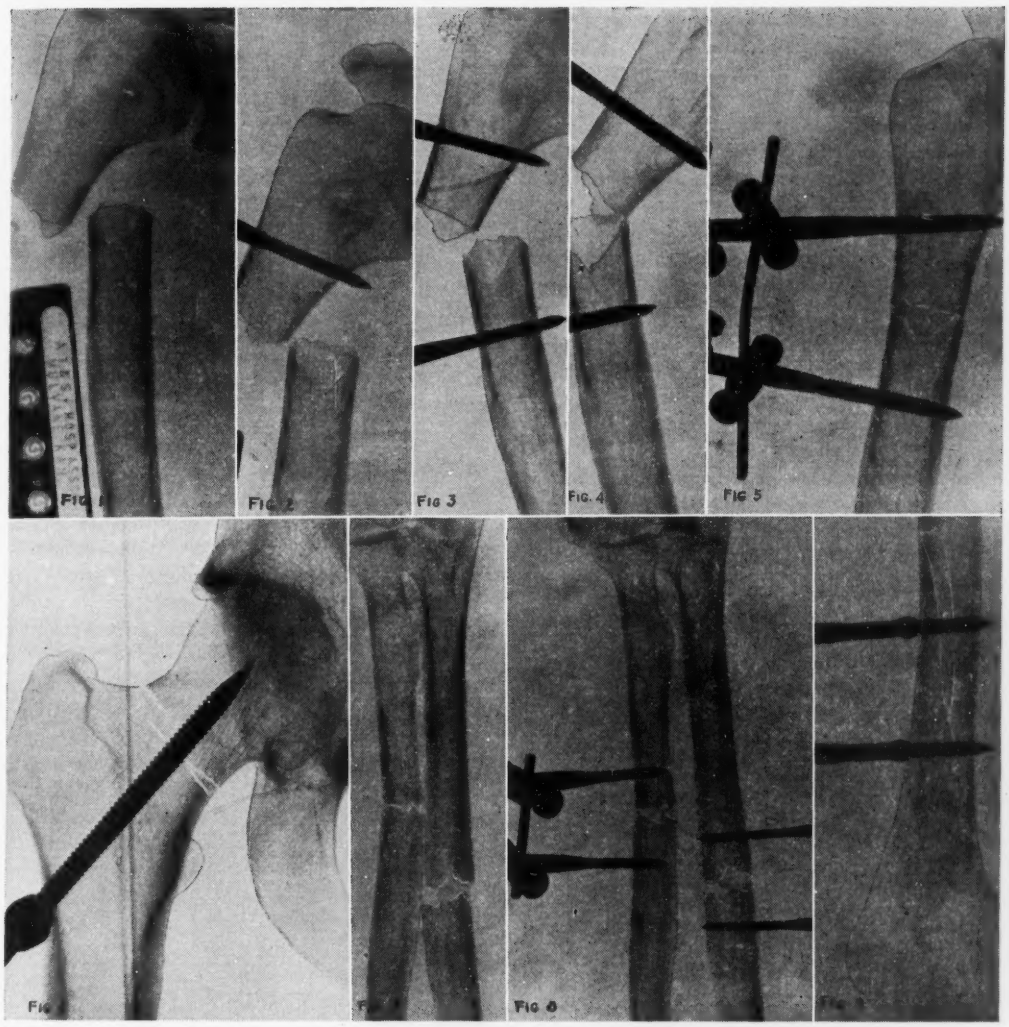
THE ADVANTAGES OF THIS METHOD

(1) It eliminates an open wound reduction in some cases.

(2) It eliminates a secondary operation.

(3) Fractures are more readily reduced, for the operator has a solid, positive hold at the distal and proximal ends of the shaft at the site of fracture, together with tremendous leverage on same.

(4) It eliminates a bulky and awkward cast in certain cases. A light splint is usually all that is required; for the drills, tie-blocks and rods are sufficient to hold almost any fracture in alignment, without heavy extraneous aid.



(5) The soft parts receive less trauma than they do with an open reduction.

(6) Less scar tissue forms; consequently, the time element for limbering up the soft parts is greatly reduced.

(7) The danger of infection is not so great as in the open operation.

(8) The operator has a positive hold on, and can easily manipulate fragments near joints that are out of alignment; these are otherwise difficult to manipulate, due to muscle pull, as shown in Figure 2.

(9) Since the drills are threaded into the cortex of the bone on each circumference, there is no slipping or pulling out of the drills. This does occur at times with nails, wires, and pins.

(10) One is usually able to start passive motion earlier, especially in fractures around the joints. The operator may remove the cast or splint each day as soon as the immediate edema has subsided, give the joint what passive motion he desires, and then replace his cast or splint.

(11) Casts or splints are easily applied under and around the drills and tie-rods.

THE DISADVANTAGES OF THIS METHOD

(1) The work must be done under fluoroscopy.

(2) It should not be used on people of advanced years because added damage may be done to the bone during the manipulation, due to the brittleness of the bone and absorption, more or less, of the medulla in elderly people.

(3) Due to the fact that the drills are inserted through a small incision in the skin, there is always the possibility of carrying in an infection.

(4) In the hands of a careless operator, too much lateral leverage may be applied to the 1/16 inch drills causing them to snap off, leaving the stub imbedded in the bone, thus making it necessary to open up to take out the piece of drill imbedded in the bone.

(5) Anyone intending to use this method should obtain some fresh animal bones of various sizes, fracture them, and then perfect himself in the use of these instruments as to drilling, the tremendous leverage he has at his command, manipulation, etc., before attempting his first work on a living subect.

RUPTURE OF SYMPHYSIS PUBIS DURING SPONTANEOUS LABOR

Chester L. Young, M.D.

Kansas City, Kansas

According to Dr. DeLee, rupture of the symphysis is rare, but not so uncommon as is generally believed. Dr. DeLee says that there is usually an inherent weakness of the pelvic girdle due to rickets, osteomalacia, relaxation of capsules, chronic rheumatism, etc., along with traumatism of labor, which accounts for most ruptures of the pelvic girdle. "The shape of the pelvic girdle, such as in a justo-minor, contracted pelvis, and the funnel varieties, predisposes, because the expansile force acts in the narrow transverse diameter". The size of the child's head and shoulders, as well as the force of labor contractions, are also factors. In three-fourths of the cases, the joint is sprung during operative delivery and the others, by the aftercoming head, the shoulders and the vectis. (Boddert).

SYMPTOMS

The patient will complain of pain over the affected joint. There may be swelling and some discoloration. The patient usually complains of discomfort in the sarco-iliac region, as well as the symphysis. There is often pain, which radiates down the leg and thigh. The legs are moved with difficulty and suggest a partial paraplegia. Bladder and rectal symptoms may be present if the separation has caused injury to them.

DIAGNOSIS

If the rupture takes place during spontaneous labor, one can usually hear a dull cracking sound at the time of rupture. The immediate results may cause considerable pain, with symptoms of shock, according to the amount of injury. The separation can be felt, as also can crepitus, along with the movement of the affected ends. The patient's legs lie everted. With movement of the legs there is pain in the symphysis. Walking is of the so-called "duck waddle" type.

The treatment is the same as a symphysiotomy. Spontaneous cure may result with firm union. There may be fibrous union, which allows excessive movement, which can cause a long disability. Infection of the joint and injury is serious. Dr. DeLee says that the mortality of reported cases is thirty-five per cent.

CASE REPORT

Patient, aged twenty-nine. A previous pregnancy eight years before resulted in normal labor. The child was reported to weigh eleven pounds. During this pregnancy internal pelvis measurements were not taken, since the patient came to the office only a few weeks previous to expected date of confinment. The blood pressure and urine were normal. The patient weighed 205 pounds, measured five feet, seven inches. She had gone two weeks past the expected time of confinement. The onset of labor was spontaneous and lasted two hours. The pains were strong and she insisted on bearing down with them. At the time the shoulders were delivered there was a dull cracking sound. After delivery examination of the perineum revealed a first degree laceration. The next day the patient complained of pain in the region of the symphysis and difficulty in moving the legs. The legs were everted and abducted. The chief complaint was of difficulty and pain when attempting to move the legs or to turn over in bed. A six inch Ace-bandage was used to encircle the pelvis, which gave considerable support. After two weeks in bed the patient insisted on getting up. The walking was of the typical "duck waddle" type. The pubic bones moved considerably with movement of the legs. The crepitus was easily demonstrated. The pubic bones became fixed at about four and one-half weeks and the patient was completely symptomless in eight weeks.

The results of any tick bite may be serious from the introduction of dangerous parasites, but the bite itself may prove harmless.—Hygeia.

It is not as a destroyer of property or as a consumer of food but as a health menace that the rat does the greatest harm.—Hygeia.

WHY PEOPLE GO TO CULTISTS*

Robert P. Knight, M.D.

Topeka, Kansas

The medical profession is sometimes accused of being smug and intolerant of healing practices or suggested methods of organizing medical care which originate from without the profession. Well grounded in scientific thinking and abreast of the latest advances in medical science, the average physician looks with disdain on therapy as practiced by cultists, brands it as unscientific, and cannot understand how the cults can continue to thrive or how they can provide any real threat to organized scientific medicine. The apathy which characterizes the average physician's attitude toward the cults was well illustrated in the recent campaign in this state of one of the non-medical schools of healing to intrude into provinces of healing which the physician regards as his own by right of his scientific medical training. But however much we may view with disdain or attempt to disregard the encroachments on scientific healing made by the various healing cults and by the patent medicine vendors, most of us realize that these unscientific ways of "treatment" enjoy a tremendous following among the public, and that an enormous annual expenditure of money flows into such non-medical channels. It should be a matter of pressing interest to the physician to try to understand how such things can be. In this paper I propose to discuss some of the factors involved. I shall inquire into two general phases of the problem: (1) the character of the power of attraction which cults have for sick people; and (2) the possible factors in the attitude of the medical profession which may turn patients away from physicians to the cultists. In conclusion, I hope to show that the ultra-scientific physician may learn some lessons from his less scientific competitors.

As a background for understanding the attraction which cults have for sick people, I must focus our attention briefly on some elements in primitive thinking. The progress of civilization, whenever it is progress, is toward an ultimate goal of scientific thinking and of utilization in all phases of living of the discoveries of science. If I use the words "science" and "scientific" repeatedly, it is because I must to emphasize their connotations. They derive from the Latin verb "scio," meaning "to know." They pertain to the mature thinking and discovering and testing of the educated man, in contrast to the irrational, magical, primitive, immature thinking of primitive man, of the child, of immature people, and of many sick persons. Most of the early struggles of civilization to progress were made against such irrational, magical thinking. But although our present civilization has reached a high scientific standard, it must never be forgotten that many of its members lag far behind the front ranks of scientific thinking, nor that each member of society must make his own individual progress from childish magical thinking to whatever level of mature scientific thinking he is capable of.

Magical, primitive thinking involves little of what we psychiatrists call "reality testing." It substitutes wished-for beliefs for scientifically determined beliefs. It projects internal psychological fears onto the environment and then behaves as if the imagined dangers were really existent. Primitive man knew no other kind of thinking; children only gradually become capable of more mature thinking and discard their childish misconceptions and superstitions; and even among us supposedly mature men of science there still may linger, in greater or lesser degree, remnants of this former fantastic, unscientific, superstitious type of thinking. Who among us is so advanced in his thought processes that he has no private superstitions—no beliefs in good and bad omens, no unrealistic lack of recognition of threatened dangers because he strongly wishes to believe he is safe, no pet rituals of doing things in ways that are actually unscientific but to which he clings because he has invested his rituals with some magical power to ensure the successful outcome of his activities? The first step toward understanding the primitive thought processes of those whom we treat, or those whom we should treat but who shun us and rely on cult therapy, is to realize the presence in ourselves of similar magical, unscientific attitudes.

How does this conflict between rational, scientific thinking and primitive, magical thinking affect the situation of choice of cult or physician by a sick person who wants to get well? Every sick or ailing person becomes more childish and tends to rely more on his supposedly forsaken magical beliefs and wishes the more sick he becomes. As a child he felt that his parents were omnipotent. He sought love and security and a feeling of well-being from them. Perhaps they even increased his belief in their magical omnipotence by telling him they would kiss his wound and it wouldn't hurt any more, or by providing the reassurance of their caresses and embraces which made him feel better when he was in pain, even though the pain was not actually lessened

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thereby. If they couldn't institute measures to relieve him they assured him that the doctor they called in would make him feel better; and they had great difficulty in getting him to understand and accept the idea that the doctor might have to hurt him or carry out some frightening procedure to make him feel better. And so, as an adult, when he becomes ill, he experiences a revival of these childish beliefs in magic or of childish fears in the face of which his adult, mature thinking may be temporarily abandoned. He is ripe for the promise of cure of a special patent medicine or of a cultist who speaks reassuringly and authoritatively. Since a considerable proportion of the population remains at the level of ignorant, childish, magical thinking, it is not difficult to see that there will be an enormous response to magical medicines, magical procedures and convincingly spoken reassurances of cure.

From the long range viewpoint, it was actually only yesterday that the most educated persons believed in the curative power of the King's touch for scrofula, of the sacred waters of some healing shrine, of religious conversion and faith. The day of belief in miracles is not past in the realm of healing, and supposedly educated, mature individuals find it hard not to believe in reported cases of miraculous cure of diseases and ailments that did not respond to medical therapy. It was only yesterday, and sometimes even still today, that belief in witchcraft existed—belief in the power of one individual to do damage to another through thinking malignant thoughts, having malicious wishes, using magical methods to bring illness or death to a selected victim. Children indulge in such hostile fantasies and primitive men organized their whole lives on the basis of such beliefs in the power of malignant thoughts to do damage to enemies and on the basis of their own magical methods to combat and undo the magic of the enemy. Even the Bible, whose teachings are espoused in toto by many people, teaches that a thought or a wish is as bad as the deed. It is but a short step from such beliefs to beliefs in the power of good thoughts. And so countless numbers of sick people needing scientific care rely instead on the good thoughts of Christian Science practitioners, or on the prayers and good thoughts of their fellow religionists, shunning the scientific remedies available to them.

The more unscientific the proposal for treatment, the greater is the exploitation of this persistent belief in magic and in the omnipotence of the healer to whom the patient turns for relief. The actual mystery, to most of us, of electricity is exploited in so-called electric treatments, with imposing looking machines. The childish experience of feeling better after parental caressing and rubbing and the racial experience of belief in the "laying on of hands" is exploited by those healers who promise relief through unscientific manipulative, touching and "rubbing" measures. The primitive belief in magical potions is exploited by patent medicine vendors. In whatever sphere of living there exist fears—fears of pain, fears of blood, fears of being poisoned internally, fears of loss of sexual potency, fears of loss of vision or hearing, fears of loss of locomotive power, fears of dread cancerous growths—one finds unscientific healing practices which provide reassuring promise of cure or relief, and one finds multitudes of people who wish to believe in these promises.

The physician realizes his limitations. He knows where the frontiers of medicine lie. He admits that certain diseases still baffle him and all his fellow-practitioners of scientific medicine. He realizes that for many human ills he has no specific curative drug or procedure and can only provide supportive measures and trust to the self-healing powers with which the patient's body is endowed. For the cultists, however, there are no frontiers, no unknown lands. They promise that their methods will cure all human ills. It is hard for even mature, educated people not to believe these assurances that they wish to believe and not to turn away from the physician, who must honestly give a doubtful prognosis, to the cultist who blithely promises a cure. This is a state of affairs that can be changed only by the slow rise in the cultural level, the slow progress of generation after generation toward a greater acceptance of scientific knowledge and a more complete discarding of primitive, magical ways of thinking.

So much for the first phase of the problem, the power of attraction that magical healing methods hold for sick people who have never outgrown or who have revived, during an illness, primitive beliefs in magic and distrust of science. Let us now examine the second part of the problem, a part about which physicians can do something. I refer to the attitudes within the medical profession which keep the cults alive, which drive people who seek medical aid away from physicians to magical, unscientific healing practices.

It is possible for "scientific medicine" to be partly blind and unscientific as well. As science developed and progressed it attempted to discard all of its previous measures and beliefs which were found to have no scientific rationale. Blood-letting for a long list of ailments was abandoned, and used only occasionally for such diseases for which a scientific basis could be presumed, such as certain cases of hypertension. Cathartic purging for many febrile diseases was abandoned when it was discovered that

this measure had been based on magical belief in internal bodily poisons which were supposed to be flushed out of the system, and that instead certain definite pathogenic agents could be discovered for different diseases, and these agents could be combated scientifically. Similarly, many therapeutic procedures utilized by medicine in the past were discarded in the light of more knowledge and newer discoveries. Medicine became scientific with a vengeance, and almost fanatically purged itself of magical, unscientific elements. Medical schools taught anatomy and physiology and pathology and bacteriology mechanistically and scientifically. The patient became a physiological machine out of order and it was up to the physician to discover the pathology and treat it. If he could discover no pathology, then the patient was certainly not sick, and was to be looked upon with disdain. He was malingering or only imagining that he was sick. Later he was called a "neurotic" and could be dismissed from consideration. This somewhat supercilious, intolerant, supposedly rigidly-scientific attitude of physicians became the pride of the upright medical man and the despair of innumerable patients who sought relief from their ills. What if their temperature, blood count and urine were all "essentially negative" and their bodies yielded no indication of pathology to the scientific examining methods of the ultra-scientific physician? They still felt sick. And in addition, they now began to feel like impostors as physician after physician disdainfully reassured them that they were all right and told them to go home and forget about it. They consumed the placebos and sedatives condescendingly prescribed for them for a while but felt no better. Then they heard of somebody with a somewhat similar set of symptoms who had taken some treatments from a certain cultist and was vastly improved. Science couldn't seem to do anything for them and they had to have relief. It was very comforting for them to hear the reassuring promises of the cultist and they readily undertook his treatments. Strangely enough they often did feel better from his treatments. Perhaps they undertook to tell their physician that the new treatments were effective. If they did, they usually encountered his disdainful smile and listened to his declarations that they were wasting their money. But they knew how they felt and they continued. Most of them didn't even bother to try to "enlighten" their former physician in the face of his attitude toward their complaints.

It is unrealistic and unscientific to attempt to discard and abandon a belief or a set of ideas without trying to understand why these beliefs and ideas existed. And this is just what medical science did with all of the former ideas and beliefs that it had embraced. It is also quite unscientific to blind oneself to the subjective factors in the patient and attempt to treat him merely as a machine out of order. But subjective factors, psychological factors, were regarded as outside the realm of science. They could not be assayed, measured, titrated, nor auscultated. They were just an intruding nuisance into the objective methods with which the physician was equipped to detect somatic pathology. If patients desperately tried to tell their stories, their troubles, their fears to the physician who was trying to percuss their chests and palpate their abdomens, he terminated the interview as soon as he could without being discourteous in order to get at other patients who were waiting and who really had a "very pretty case of apical tuberculosis" which he had triumphantly detected, or a "beautiful kidney tumor" in regard to whom he longed for an autopsy in order to get the specimen for his shelves. I do not need to point out the obvious effect of such an attitude in driving patients to the cultists.

It is a step of progress which scientifically grounded physicians find it difficult to take, to accept the fact that there is also a science of subjective factors in the patient, a science of psychological processes, and to realize that disturbed emotions can cause complaints referable to organs. They are inclined to view with distrust the opening up of such a wide realm as the psychology of the patient, with all of its intricate complications, its subjectivity, its apparently fantastic quality. Even the scientific researches into the autonomic nervous system and the endocrine glands were distrusted at first because they seemed to pertain to a kind of bodily activity which was subjective and bewildering. The intricate inter-relations between emotions on the one hand and autonomic activity and glandular secretions on the other seemed to be a further plunge into the unknown, apparently away from the tenets of objective science. And when the investigation of the emotions involved attention to dreams and fantasies and "foolish" fears, and there was talk about the unconscious and the effect of childhood experiences, this seemed indeed to be getting into deep water.

But regardless of whether the physician is able to assimilate such subjective factors into his scientific concepts, there remains the reality of a large per cent among his patients of individuals with functional complaints, people who are not malingering, who are not imagining they are sick, but people who are sick, and whose sickness can be understood and treated only in terms of these despised subjective factors. Furthermore, one cannot escape the fact that a patient who has a physical illness is also

psychologically sick at the same time, and needs treatment from both aspects, physical and psychological. A physician who administers the correct treatment for the former but neglects the latter may fail to cure the patient, while another physician who administers the identical treatment for the former may succeed in curing the patient if he also understands and treats the psychological aspect of his patient. Treating this latter aspect may involve nothing more than sympathetic listening to the heightened worries and fears that accompany the physical illness, with appropriate advice and reassurance; it may involve drawing out concurrent conscious personality disturbances and conflicts and pointing out the relationships of these to the physical symptoms; it may involve more delicate probing into the intimate life of the patient and the bringing to light for intelligent, scientific solution of hidden disturbing fears and psychological conflicts. The physician was not taught how to do this in medical school. If, in spite of his training in strict medical science, he preserved his interest in people as people and did not come to regard them as a collection of pathological organs, his own knowledge of the inner psychological life of human beings may have been sufficient so that he could himself handle many psychological difficulties which complicated the physical illness of patients he treated, or which were the main illness of the patient. If his training was such that it shut out all such appreciation of his patients as individuals, each with his own psychological difficulties, then he must learn some more science in the field of human psychology.

And now in conclusion we come to certain aspects of cultists' management of their patients from the study of which physicians may profit. We observe that in spite of our ideals of reaching to higher levels of science, cold science alone, mechanistic science, for want of a better term, will not suffice. There is a science of human psychology, of treating and handling human personalities. This means comprehending, understanding, and managing the magical, primitive beliefs, wishes, and fears of patients who either have never been able to discard these and espouse mature, scientific attitudes, or who, under the stress of illness have fallen back on their supposedly discarded childish ways of thinking and feeling. The cultists are superficially correct in their meeting these needs for magic, for omnipotent assurance of cure, in their taking all of the patient's complaints seriously and sympathetically. Unfortunately, it becomes a case of the blind leading the blind; of magic applied to combat magic, without deeper understanding of the psychological factors involved, and, of course, without appreciation of the actual organic pathology present in those patients who are organically ill. Physicians must realize that some patients do get relief and do "get well" by cult treatment, simply because their psychological needs are met and satisfied by the treatment given, and must realize that these patients could have been treated successfully by physicians without employment of measures which are unscientific. For all treatment measures which meet the needs of the patient, either physiological or psychological, are ipso facto scientific in the broadest sense of the term. But one must know what he is doing, and must not develop a theory of illness on the basis of the success of the measures used, as, for example, basing a theory of disease and therapy on subluxation of the spinal vertebrae simply because rubbing the back of the patient makes him feel better.

Physicians are, on the whole, too sparing with their reassurances to patients. In trying to be scientifically honest they fail to meet the patient's need to be assured of help against the destructive process within him which has aroused his anxiety. They are too contemptuous of physiotherapy—massage, passive exercise, and the like—and have let the cultists exploit this valuable field. People like to be rubbed and massaged, and they often feel much better after such measures are used, but aside from getting a massage from the nurse when bedfast in the hospital, they find it hard to get such soothing procedures prescribed by physicians. They must go to Swedish masseurs, or to osteopaths or chiropractors, or to spas where healing waters are applied internally and externally and a good rub-down is included. Physicians are, on the whole, too uninterested in or too intolerant of the story of his trouble the psychologically sick patient wants to tell. If he is afraid of going to a psychiatrist for fear that will stigmatize him, he must find the sympathetic ear of his minister, or of a Christian Science practitioner, or of a charlatan "adviser" on personal problems. All of these measures should properly be within the realm of scientific medicine. There is no surer way to eliminate unscientific exploitation of them, and thus to eliminate cults.

Cults must be taken seriously by the medical profession, not only in order to combat their encroachments on medical practice, but also, and more especially, to study and understand the psychological factors which cause people to go to cultists in preference to physicians. In order to progress further toward their scientific goal, physicians must, paradoxically enough, abandon the materialistically scientific attitude which excludes study of emotional factors involved in patients' illnesses and espouse a higher scientific attitude which tries to understand

everything about the patient's behavior and feelings in addition to his structure and physiology. When that goal is reached, every patient, regardless of the unscientific character of his thinking, behavior, and complaints, may expect to find scientific understanding and scientific treatment in his physician.

ADDISON'S DISEASE, REPORT OF AN UNUSUAL CASE

Frederic W. Hall, M.D.*

Halstead, Kansas

Case: Mr. B. B., a white male, age fifty-five, came to the hospital on September 20, 1938, requesting a hemorrhoidectomy. He was admitted on the medical service because he appeared to be cyanotic. On admission the patient stated that he had been bothered by painful hemorrhoids at times for the past two or three years, which bled and protruded on occasion. He had also had some mild vague aching of the joints, with some stiffness, for the past eighteen months.

Direct questioning brought out that five months previously the patient had noticed a brownish discoloration of the hands and wrists, which gradually became darker over a period of about three weeks, but apparently had not changed since. There had been no gastro-intestinal upset, nor had the patient noticed any particular weakness. He had lost twenty pounds during the past five months, which he attributed to financial worry.

The past history revealed amputation of the left foot in 1907, following injury; a fractured skull in 1912; a transitory right facial paralysis in 1912; an appendectomy in 1925; and fracture of the left hip in 1934. The patient had a chancre in 1906, and was given potash and mercury for a time afterwards. He had a rash in 1911 and was given fifteen intramuscular injections and ten intravenous injections of salvarsan. He stated that repeated Wassermanns had all been negative.

Physical examination revealed the patient to be a well developed, very well nourished, white male weighing 185 pounds. The skin of the face, neck, hands and wrists showed a marked brown pigmentation, that of the perineum and axillae slightly pigmented, and that of the scrotum and penis almost black. The pupils were round and equal, reacted readily to light and accommodation. No abnormal pigmentation was noted in the mouth. The neck was negative. The chest was resonant throughout, no rales were heard. The heart was of normal size, the tones distant. The pulse was ninety-six and regular, blood pressure 92/54. Examination of the abdomen revealed no masses, tenderness, fluid or rigidity. The extremities were negative except for the noted pigmentation and absence of the left foot. Reflexes were normal except for the absence of the right knee jerk. Rectal examination revealed a redundant mucosa and several internal hemorrhoids. The prostate was normal.

Laboratory reports revealed a hemoglobin of eighty-nine per cent, with 4,480,000 red blood cells; white cells 4,450, with thirty-eight per cent lymphocytes, forty-five per cent segmented cells, five per cent stabs, and twelve per cent monocytes. The urine was negative. Both the Kolmer and Kahn were four plus. Pellagra decolorization test was positive. The interdermal tuberculin test was two plus positive.

The patient had no further complaints until 8:00 p.m. of September 22 when he suddenly became nauseated and vomited, and complained of a severe generalized aching. He had a severe chill, followed by a slowly rising fever which reached 104.4 degrees F. by 6:00 a.m. of September 23. The nausea, general malaise and aching persisted. The pulse rate rose to 144. The chest was clear. At 3:00 p.m. the pulse was 156, respirations thirty, blood pressure 36/26, and temperature 103 degrees F. The patient was drowsy and appeared toxic. The percussion note in the entire lower chest was impaired, breath sounds absent, but no rales were heard.

The administration of saline and adrenalin intravenously, and metrazol intramuscularly, raised the blood pressure to 64/20. Cheyne-Stokes respiration appeared, the patient gradually became more stuporous, the extremities cold, and he expired at midnight. There was suppression of urine during the last twelve hours.

AUTOPSY REPORT

The body is that of a well developed, well nourished, white male approximately fifty-five years of age. The left foot and ankle are absent. The skin of the face, exposed portions of the neck, hands and wrists, elbows, penis and scrotum, and ankle is of a dark, brown walnut hue.

Examination of the thorax reveals a normal amount of fluid in both pleural cavities. The right pleural cavity contains old fibrous adhesions in the upper third of the postero-lateral portion. The lungs show rather marked congestion in the bases. The tracheobronchial lymph nodes are not enlarged or calcerous. Serial sections through both lungs reveal no evidence of tubercles or tumor. The pericardium contains a normal amount of fluid. The heart is

*From the Department of Internal Medicine, The Hertzler Clinic, Halstead, Kansas.

approximately of normal size, shape and consistency. The heart cavities show no deviation from normal, valves are free of any pathology. The coronary vessels are normal.

Examination of the abdomen reveals the gastro-intestinal tract to be essentially negative except for a moderately dilated stomach. The liver is grossly normal except for chronic passive congestion. The gallbladder is filled with normal gallbladder bile, no stones. The spleen is approximately twice normal size; chronic perisplenitis is present. Cross section shows the pulp to be very soft, rather bright red and semi-fluid. No nodules are discernible.

The right kidney is encased in an excessive amount of perirenal fat which includes the suprarenal gland. Section of the mass reveals the fat tissues to be firmly adhered to the suprarenal and the kidney. The kidney is moderately enlarged with numerous retention cysts on the surface, the capsule strips with moderately increased resistance, leaving a very finely granular surface. Section of the kidney reveals the cortex and medulla to be well differentiated, the pyramids easily made out. The pelvis is filled with fat. The left kidney is also encased in a large amount of fat. The whole mass was removed, and in so doing there is left on the posterior lateral wall of the abdomen an oval area measuring approximately 5 x 3 cm., which is of a brownish hue and presents a granular surface. The kidney corresponds grossly to that of the right.

The right suprarenal measures 7 x 5 x 3 cm. The gland is firm and nodular. Section reveals several large and small areas involving practically the whole of the organ, the surface of which is grayish-yellow and cheesy. About three cm. from the hilum of the gland is a node the size of a marble which on cross section shows a grayish-yellow cheesy area involving practically the entire node. All that is found of the left suprarenal gland is a brown plaque of tissue on the surface of the perirenal fat, approximately two mm. in thickness, which corresponds with the area left on the posterior wall of the abdomen when the mass was removed.

The bladder and prostate show no pathology.

The peri-aortic lymph nodes at the level of the right kidney hilum are enlarged and firm. Cross section of one of these reveals a grayish-yellow caseous center.

MICROSCOPIC REPORT

The right adrenal gland shows a large, sharply outlined area of fibro-caseous degeneration. The first zone of cells beyond the degenerated area is of an imperfect pallisade arrangement, the nuclei being elongated, with the axis at right angles to the center. The next zone of granulomatous cell formation is very thin and is made up of fibroblasts, a few round cells, and many cells of epitheloid character. There are a few giant cells of the typical tuberculous type, surrounded by rather badly developed epithelial

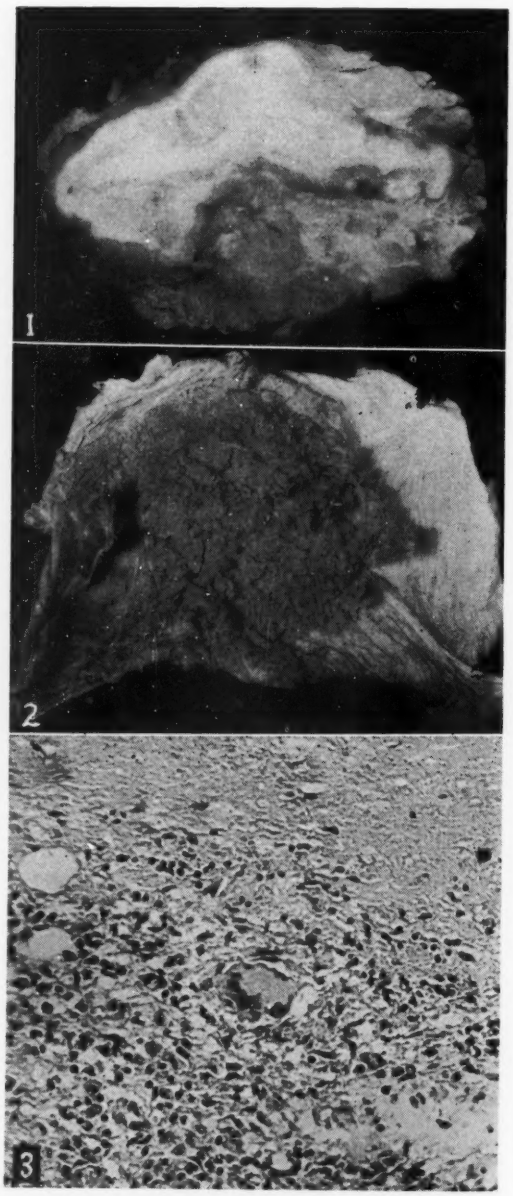

Fig. 1. Cross section of right adrenal gland. Normal structure completely replaced by cheezy caseous material.
Fig. 2. Left adrenal gland split in two. Cortex thin and firmly adherent to capsule of kidney by old inflammatory tissue.
Fig. 3. Microphotograph of section of right adrenal. Caseation necrosis, typical tuberculous giant cell, epitheloid cell proliferation, and a few lymphocytes make up the inflammatory area.

zones. There are no lymphocytes surrounding these tubercles. The blood vessels in this affected tissue show no end-arteritis or other changes. The surrounding fat is unchanged.

The left adrenal gland has been divided by splitting, one half being left in the cadaver. Beneath the capsule only the cortical cells remain, which are surprisingly well preserved. In the capsular wall are a few giant cells identical with those found in the right adrenal gland, but they are not as large or definite.

The peri-aortic gland show exactly the same type of change as that seen in the adrenals and in addition there are small foci of calcification seen. The gland from the hilum of the right adrenal shows the same changes. The spleen shows areas of coagulation necrosis that faintly suggest old and completely matured tubercules. Definite giant cell formation is not present. The only significant change in the kidneys is tubular degeneration and atrophy, especially in the loop of Henle.

Section of the lungs shows an old fibrotic change and chronic passive congestion. The pulmonary alveoli are difficult to make out. Here and there are small areas which apparently are alveoli completely filled by material resembling the basal matter out of which giant cells are formed. No definite giant cell formation can be identified.

The microscopic examination of the other organs is negative for any suggestive findings.

PATHOLOGICAL DIAGNOSIS

(1) Very chronic fibro-caseous tuberculous degeneration of the adrenal glands with similar changes in the adjacent lymph nodes. (2) Questionable tuberculosis of the spleen and apex of the lung.

COMMENT

The cardinal symptoms of Addison's disease are asthenia, gastro-intestinal disturbances, abnormal pigmentation, and hypotension. Asthenia is the symptom that is most marked in the vast majority of cases. Pigmentation may precede or follow the appearance of the weakness. Usually there are periods of nausea and vomiting throughout the course of the disease. Death occurs either during a sudden crisis or by gradual debilitation.

This patient presented no evidence of asthenia, either subjective or objective, nor any gastro-intestinal upsets. His general physical condition appeared to be excellent until the day before death. Suddenly, for no known reason, he developed a typical hypo-suprarenal crisis and died. The diagnosis of Addison's disease was made solely upon the presence of hypotension and abnormal pigmentation. Surgery, had it been done, certainly would have been immediately disastrous to the profound embarrassment of an uncautious surgeon.

The pathological picture is that of tuberculous degeneration of the adrenals, without, as is frequently the case, any demonstrable active tuberculous process elsewhere in the body. The type of necrosis, and the absence of end-arteritic changes, make the role of syphilis in the production of the degeneration of the glands doubtful.

BILATERAL POSTOPERATIVE PAROTITIS: RECOVERY AFTER SULFANILAMIDE AND ROENTGEN THERAPY*

Maurice A. Walker, M.D.

Lewis G. Allen, M.D.

Kansas City, Kansas

and

M. J. Owens, M.D.

Kansas City, Missouri

A white man, aged twenty-five, was first seen on Setember 23, 1938, with the typical symptoms and physical findings of acute appendicitis of about forty-eight hours duration. At operation soon after admission to St. Margaret's Hospital, the distal half of the appendix was gangrenous and had perforated into its mesentery. The appendix was removed and a small soft rubber drain was placed in the pelvis.

Convalescence was entirely uneventful so far as the abdomen was concerned. On the morning of September 28, however, he complained of pain in both parotid regions. By noon both glands were tensely swollen and his temperature and pulse rate had begun to rise. These reached a maximum in the evening of the next day when his temperature was 104.4 F. and pulse rate, 130. Swelling of the parotid regions was also greatest at this time.

Roentgen therapy was begun at noon of September 28, as soon as the condition was recognized. Approximately 125 r units, measured in air, at moderate voltage, was given to each gland on September 28, 29, 30 and October 1 and 3. Sulfanilamide, ten grains, was given every six hours. The swelling began to decrease on October 1, with gradual improvement in his general condition. On October 10 a small fluctuating mass in the right parotid gland was incised. About thirty cc of thick gray pus was obtained from

* From the University of Kansas School of Medicine.

which a staphylococcus was subsequently grown. This incision healed within a few days.

He was allowed out of bed on October 14 and left the hospital on October 16. An increased firmness of both parotid glands could be felt, more marked on the right, as late as December 31. When examined on February 10, 1939, both glands felt normal.

SUPPLEMENTARY MEASURES IN THE TREATMENT OF PNEUMONIA*

Claude D. Head, Jr., M.D.**

Washington, D. C.

Aside from specific therapeutic serum and the newer forms of chemotherapy, there are certain fundamental measures whose merits have been recognized for many years and which today still play a vital role in the outcome of any given case. Even in recent years they have often been the only methods of treatment available to a pneumonia patient, because of the cost of serum, the lack of the specific type at the time and place required, the sensitivity of the patient to serum, or the limited experience of the physician in the proper use of this agent. These important measures include adequate nursing care, proper diet, administration of oxygen, judicious use of drugs, and management of complications.

Before the availability of specific therapy many a doctor said, "If I get pneumonia, give me a good nurse instead of a doctor!" This indicates the high regard held for adequate nursing care. It has been aptly stated that to provide for the patient the maximum rest compatible with adequate nutrition and elimination is the fundamental purpose toward which all nursing procedures should be directed, and that maximum rest for the patient usually means minimum rest for the nurse.[1] In pneumonia, which seriously affects the mechanism by which the body's supply of oxygen is constantly replenished, she should anticipate as much as possible the personal needs of the patient and thus eliminate unnecessary physical activity or restlessness. Good oral care, washing of the face and hands, application of alcohol sponges for the relief of fever and restlessness, and assistance in feeding are but a few of the many aspects of nursing care which contribute immeasurably to the comfort of the patient. Every effort should be made to guard against the development of bed sores. Frequent changes of linen to insure a smooth, dry and clean bed, variation of the patient's position and regular examination of his back, especially over the bony prominences, are of value in preventing this unfortunate occurrence. The importance of sleep to recovery can not be overemphasized. It is truly "Nature's sweet restorer," and under no circumstances should it be broken for the taking of the pulse or temperature, or even the giving of food. Interruption of sound sleep at 5:30 or 6:00 a..m. by the night nurse for the washing of the face and hands of the patient before breakfast should never be permitted. The nurse should also realize that pneumonia is an acute communicable disease, and should be treated as such with the use of isolation technic. Solicitous friends and members of the family other than those actually taking care of the patient should be excluded from the sickroom, not only to prevent the possibility of transfer of the pneumococcus to them, but also to protect the patient from exposure to still another organism.

In addition to contributing to the comfort of the patient, the nurse plays an important part in oxygen therapy. Knowledge of the indications for its use and familiarity with the devices commonly employed determine to a large extent the success of this method of treatment. If the closed tent is used, the nurse should understand the operation of the various gauges and controls essential to its efficient functioning. She should also know how to care for the patient without unnecessary and prolonged opening of the tent. In oxygen administration by the nasal catheter or the inhaler, it is her duty to see that the device is constantly in place, that the orifices are free from mucus, and that the tube leading from the tank is not kinked. As a precaution against the possible overturning of the tank, it should be strapped securely to the head of the bed. The pressure gauge should be read from time to time, and a new cylinder provided when the one in use is nearly depleted. In oxygen therapy fire is one of the most serious hazards to be avoided. It need only be mentioned that well-meaning but thoughtless visitors have been observed passing matches and cigarettes to a patient within a tent to emphasize the fact that eternal vigilance is the price of safety.

The variability in the duration of pneumonia makes adequate nourishment indispensable to the maintenance of resistance to infection. Patients will have need of more and not less food than when they are well because of increased metabolism resulting from fever (7.2 percent for each degree Fahrenheit that the body temperature is elevated above normal[2]) and from restlessness or delirium. Frequently the total amount required is as high as 3500 or 4000

*Past Assistant Surgeon, United Public Health Service, Washington, D. C.

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calories per day. Sufficient readily absorbed food, chiefly carbohydrate, should be supplied to prevent emaciation. Meat and meat extracts are valuable vehicles for the provision of salt and carbohydrates. Fluids should be given in liberal quantities, about 3000 cc. daily, to replace what is lost through high fever, rapid respiration and profuse sweating. This depletion coupled with loss of appetite, nausea and exhaustion may readily lead to severe dehydration. According to individual tastes, the patient may depend upon plain water alone, or may supplement carbonated waters, fruit juices, milk, broth and cooked cereals.

The provision of salt for the pneumonia patient has often been overlooked. The body loses chlorides at the onset of the disease. It has long been noted that the blood chloride level is lowered. Excretion of salt by the kidneys may become almost nil in spite of an apparently adequate intake. There is no satisfactory explanation of where the salt is stored, although experimental work on dogs has indicated that the depot is in the diseased lobe or lung itself. Bullowa has stated that the loss of chlorides is harmful and causes interference with the function of the adrenals.[2] It is his practice to give patients about 3 or 4 grams of salt two or three times a day in addition to the salt normally obtained in food. This is given in tablets, capsules, or in solution, and there is seldom objection on the part of the patient.

In few other diseases does the administration of oxygen play as vital a role as in pneumonia. In this disease anoxia, or oxygen want in the tissues, may be attributed to either an increase in the demand for oxygen or to a decrease in its supply. The first condition occurs when fever has produced a rise in the metabolism of the patient. The second is usually associated with a reduction in the alveolar area available for oxygen transfer. This may result from the consolidation of one or more lobes, or from the compression of the unaffected area of the lung by air (as in pneumothorax) or fluid (as in empyema). Prolonged anoxia may be responsible for cytolysis of cerebral cells which may result in permanent damage.

Indications for oxygen therapy are (1) increased pulse or respiratory rate, (2) cyanosis, (3) distention, and (4) pulmonary edema. Some authorities consider it best not to wait until cyanosis has appeared to begin oxygen therapy but to give additional oxygen to a patient with pneumonia when the pulse rate remains above 120 or when the respiratory rate remains above thirty-six. If used early, oxygen should help to prevent cyanosis and distention; if these conditions are already present, oxygen will help bring relief.

Oxygen may be given by chamber, any one of a number of tents, nasal catheter, or mask. The oxygen chamber where temperature, humidity and concentrainon of O_2 and CO_2 may be readily and automatically controlled is the ideal method, but its cost is prohibitive except in research institutions and in large hospitals. Tents, if properly applied and intelligently managed, will closely approximate the air-conditioning features of a chamber. To be certain of the O_2 concentration within the tent, however, (in spite of the claims of various manufacturers), it is necessary to test the air within the tent at regular and frequent intervals. This can be readily done by a trained attendant. Many patients object to the closed tent because of claustrophobia. The oxygen chamber obviates this objection. The concentration of O_2 in the chamber and tent under ordinary conditions should be kept at about fifty percent and the temperature at about sixty degrees F.

The administration of oxygen by means of a nasal catheter passed into the nasopharynx is objectionable because the dry gas impinging constantly upon the mucous membrane in one place is apt to be irritating. This method may be used in an emergency if no other is available.

The nasal inhaler[2] overcomes these objections and its low cost and ready availability probably make it the method of choice. The inhaler is a forked or pronged metal instrument with rubber tips leading just inside the nostrils. It is made of malleable brass to permit moulding to the nose and can be obtained in sizes for children and for adults. The hand plate is strapped to the forehead. The oxygen is bubbled through water to add moisture before being brought to the inhaler by rubber tubing. The flow rate is usually set at about four or five liters per minute. This has been found to give an alveolar oxygen concentration of about forty-five percent, and in most instances is sufficient to overcome the usually encountered grades of anoxia.

The advent of pulmonary edema calls for the use of the face mask by means of which oxygen in concentrations of above ninety percent may be administered to the patient for short periods of time.

In the management of the pneumonias, drugs other than those for specific therapy are of definite though perhaps limited value. Time will permit only a brief discussion of those most commonly used. At the onset, when pleuritic pain is severe and robs the patient of much needed rest and sleep, morphine will diminish the threshold of pain and induce sleep. Its depressing effect upon the respiratory center must be considered, and if used at all it should be restricted to the time of onset, administered in small doses (grain 1/6), and not repeated.

(Continued on Page 302)

PRESIDENT'S PAGE

To The Members of the Kansas Medical Society:

On another page of this issue there will be found a list of the committees for the ensuing year. In appointing these committees we have attempted to distribute the work as widely as possible. First, so that the committee work would not be irksome for any one person, that the load upon the individual would not be too great. Secondly, in order to give to as many members as possible an opportunity to make a contribution to the grand total of organized medicine.

We have, with but one or two exceptions, left from our committees all members of the council and officers of the state society. There is one committee which is a notable exception to this principle. On that committee are found the names of three members of the council. The excuse for this exception is that the membership of the committee has been quite constant for a number of years and they are in the midst of an uncompleted program.

We have attempted to distribute committee membership as widely as possible, both numerically and geographically. We have in the case of each committee charted the committee upon a map of the state in order that in so far as possible all sections of the state may be represented.

In order that the list of committees may be published in the July issue it has been impossible to write each member of the various committees asking that the member signify his willingness to serve. In the years past the membership has always signified willingness to serve and responded to assignments so readily that it lead us to assume that each of you would be willing to serve without having been consulted in advance.

There is one committee that I would like especially to mention and that is the Committee on Scientific Work. We have enlarged that committee and we are going to ask that they assume for this next year some added duties. We are asking them to consider as a part of their duties not only contributions to the program of the state society but postgraduate courses. Throughout the year to attempt to stimulate an increased interest in the scientific exhibits by members at the state society, and to accept as their responsibility the promotion of every possible opportunity for increased scientific work.

Your president,

C. C. NESSELRODE, M.D.,

EDITORIAL

PRESS RELATIONS

One of the favorite vices of the daily press is the indulgence in coloring news involving the medical profession for the purpose of discrediting doctors and their motives in taking care of the poor. In an almost unanimously conservative daily press it is not uncommon to find headlines which betray the dubious art of editorializing and a not unusual practice to create "color" in a news story at the expense of determined facts. There is an attitude of suspicion and mistrust of the medical profession. Doctors of medicine do not buy advertising space and the business office resents it. It is well known in many localities that it is necessary for the county medical society to buy advertising in order to build up friendship in the editorial rooms of newspapers. A belligerent attitude toward the medical profession grows out of a lack of commercial relationship.

Criticism of the medical profession is chiefly from groups especially interested in radical social change. There is a strange paradox expressed when daily newspapers join in the "putsch" for socialized medicine. When the press attacks or misrepresents the medical profession there is a certain devilish glee in the minds of those who would destroy private medical practice.

The whole difficulty between the daily press and the medical profession arises from the essential dishonesty of medical advertising. The medical profession is a small minority, powerless to combat unfair tactics upon the part of the press. It is as impossible to shame the press as it is to reform it. After all, the daily press has its foundation in public confidence that it present the truth. With all its superstructure of wealth and commercial enterprise, without truthfulness, the daily press will cease to influence the public.

The medical profession serves essential needs of the population. It has done so before there were newspapers and it will continue to serve. If the press has any function left as a guardian of public welfare it is through intelligent and truthful reporting of the news and an editorial policy based upon a philosophy acceptable to the public which is constantly learning.

JOURNAL INDEX REVEALS VAST SCOPE OF A. M. A. ACTIVITIES

Some conception of the vast scope of the work of the American Medical Association is contained in the semi-annual Index Number (June 24) of the Association's Journal, an editorial in that issue points out, saying that:

"It is recommended particularly that readers consult page 2644 of the index under the heading 'American Medical Association.' A survey of the material listed will indicate the vast scope of the activities of the Association at this time. It is in a sense a review of the work for the first six months of the year.

"Few people realize the information to be derived merely from turning the pages of an index one by one. For example, the relative amounts of material on page 2646 concerned with anaphylaxis and allergy and with androgens indicate the extraordinary development of interest in the latter subject during the period covered by this volume.

"No other medical periodical provides in a six months period the amount of information available through The Journal of the American Medical Association. It is with pardonable pride that we assert that the physician who wants to keep abreast of the scientific, political, economic, social, literary or any other phase of medicine can do so by consistent, thorough reading of this publication."

THREAT TO HEALTH

The advertisement of laxatives over the radio has assumed disquieting proportions. As its volume soars to new highs, its quality drops to ever lower levels.

To hear the ecstatic descriptions of the taste, efficacy, and safety of numerous products ballyhooed over the air, one might think that the use of laxatives is normal and entirely harmless. That this

is far from the truth is demonstrated in an article appearing in a recent issue of the Journal of the American Medical Association.

Among 1,000 adult cases of appendicitis occurring in Cleveland between 1931 and 1936, the death rate in the acute suppurative type jumped sharply over the preceding five years because of delayed surgery. The authors of the report—Drs. F. R. Kelly and R. M. Watkins—attribute the fatal delay in seeking surgery "to economic factors and use of home remedies, including laxatives. . . . " In the 1925-1930 series of cases, forty-two per cent tried laxatives prior to medical aid. In the 1931-1936 series, this percentage jumped to sixty-seven.

Dr. Kelly and Dr. Watkins point out that they are not alone in the serious view they take of the unsupervised use of laxatives for abdominal pain. In a report on a series of 306 fatal cases of acute suppurative appendicitis, Dr. J. O. Bower, of Philadelphia, observes that 147 had taken laxatives at the onset of pain. The percentage is 91.6 in another series of 214 patients who died of acute diffuse peritonitis following appendicitis.

This is only one, albeit an extremely serious, aspect of the unsupervised use of laxatives. The development of normal eliminative habits is of primary importance to health, particularly in childhood. To start a child on the laxative habit is a crime against nature. Yet ten or twelve times a day the biggest and best radio stations permit advertisers to urge parents to give their children this or that wonderful cathartic. One tastes like delicious candy; another works like a miracle; a third cements affectionate relations between mother and child. No reason is too inane or fallacious. In all the arguments advanced there is an arrant deception in the implication that the use of laxatives is without harmful consequences.

The laxative habit is one of the serious problems of American public health education. There is little hope of breaking its grip until newspapers, magazines, and radio broadcasting stations develop enough social conscience to reject this type of advertising. —New York State Journal of Medicine, June, 1939.

CANCER CONTROL

CANCER OF THE OVARIES

Harold V. Holter, M.D.

Kansas City, Kansas

Cancer of the ovaries may be either primary or secondary. The majority of cancers of the ovaries are those which arise in a cyst.

Etiology. This must be given under the various types of ovarian cysts.

Proliferating cysts of the ovaries. They are those cysts which are capable of growing within themselves. There are two types, the pseudomucinous and the papillary cysts.

A. The pseudomucinous cysts contain a jelly-like secretion which is secreted by the lining epithelial cells. These cysts, when they rupture, give rise to the pseudomyxoma peritonae. Mucoceles of the appendix also give rise to this condition. This pseudomucin may be secreted in large amounts and the cyst may rupture spontaneously. The peritoneal metastases secrete and frequently cause mechanical blockage. These cysts rarely undergo malignant change.

B. The Papillary Cysts: They are sometimes known as cystadenoma invertens, and secrete only a small amount of serous secretion. The cells within proliferate and send papillary projections into the cavity of the cyst. These papillary growths reach the opposite wall of the cyst, penetrate the wall, and appear as cauliflower growths on the outside of the cyst. Eventually they may replace the entire cyst, and metastasize and fill the entire pelvis. They frequently become malignant by undergoing malignant change. They frequently are bi-lateral. Grossly, it is difficult to tell whether the papillary cyst has become malignant.

Diagnosis: A rapidly growing single or bi-lateral tumor of the ovary is potentially malignant. Abdominal section should be done. The most common period of time for the development of these cysts, as in most ovarian tumors, is during the years of most active ovarian secretion.

Treatment: The age of the patient will determine to some extent the preoperative use, in ovarian tumors, of intrauterine radium and deep x-ray therapy. In those women at or near the menopause,

*Presented at the 80th Annual Session of The Kansas Medical Society, May 1-4, 1939, Topeka, Kansas.

it may be advisable to precede operative procedure with deep x-ray therapy. In younger women with ovarian tumors, it is best to operate first, and if the tumor is malignant, follow with deep x-ray treatments.

Operative Procedure: Operative procedure should be radical. Bi-lateral salpingo-oopherectomy and hysterectomy should be performed, if the growth is not too advanced. This is because the ovarian malignancies are so frequently bi-lateral. Deep x-ray therapy should follow removal of malignant ovaries.

If the malignancy of the ovary is so advanced that removal is impossible, radium and x-ray therapy is of some value, for the same reasons as stated in the treatment of the corpus cancer.

Solid carcinoma of the ovaries are rare. They may be scirrhous or adenomatous. They infilterate diffusely.

Adenomas of the ovary develop probably from misplaced tissue of endometrial origin. They may undergo degeneration into adenocarcinomas of the ovary, which are usually bi-lateral.

Dermoid cysts of the ovary arise from undifferentiated somatic cells or embryologic rests in the ovary. Their contents are usually those of the skin elements. They usually contain sebaceous secretion, hair, teeth, cartilage and bone. They may be bilateral. They should be removed as soon as the diagnosis is made, because they not infrequently undergo malignant change, and if they rupture, they frequently cause severe peritonitis.

Teratomata are rare ovarian tumors. They are related to the dermoid cyst, but contain all three embryonic layers. They are solid tumors of the ovary, with small cystic cavities. They are malignant and should be removed. X-ray therapy should follow.

Granulosa cell tumors of the ovary are probably embryonic rests of undifferentiated cells. In this type of tumor the cells have a female tendency. If they grow in the child, they produce precocious sex development. In the menopause, they cause a return of the menstrual periods. There is a tendency toward erratic cell growth and malignancy. Therefore the granulosa cell tumor should be removed.

Arrhenoblastoma of the ovary is similar in character to the granulosa cell tumor, except that the embryonic rests of sex cells have a male tendency. There is a suppression of female characteristics. The growth of hair tends to become masculine, the voice deepens, the breasts flatten, and the clitoris enlarges. There is a tendency to erratic cell growth and malignancy. Therefore they should be removed.

Parovarium Tumors are embryologic remnants of the Wolffian body. They are usually broad ligament tumors. They frequently become proliferating papillary cysts and develop the warty cauliflower growths as described under papillary cysts of the ovaries. Since they are intra-ligamentous cysts, they frequently displace the pelvic organs and give rise to early symptoms. As in papillary cysts of the ovaries, they may undergo malignant changes. Therefore the treatment is the same as given previously.

Secondary carcinoma of the ovaries: They are usually bi-lateral and are frequently associated with pelvic infiltration of the cul-de-sac. They may be secondary to cancer of the body of the uterus, to the stomach, or gastro-intestinal tract. The Krukenberg tumors of the ovaries are examples of this type. It is important in bi-lateral tumors of the ovary to suspect primary malignancy of the stomach, gall bladder, or gastro-intestinal tract. Intestinal x-rays may be valuable before operative procedure on bi-lateral ovarian tumors. This may prevent operating inoperable metastatic pelvic carcinoma.

Sarcomas of the ovary are rare. They are often bi-lateral. They are usually of the firm, spindle cell variety. The treatment is the same as that of carcinoma of the ovary.

Prognosis: The prognosis of cancer of the ovaries is poor. Cancer breaks through the capsule early and metastasizes early. Early radical operative procedures, followed by pelvic deep x-ray therapy is the treatment of choice. The five year survival rate is about twenty per cent.

Conclusion: Malignancies of the corpus uteri and adnexae require careful history analysis, examination and diagnosis. As in malignancy elsewhere, our hope of cure lies in early recognition of the disease, and in prompt treatment. Proper consultation of the gynecologist, internist, and x-ray therapist will yield best results.

EYE, EAR, NOSE & THROAT

AN UNUSUAL MASTOID CASE

Perry A. Loyd, M.D.

Salina, Kansas

The patient, a boy age nine years, had always been in good health. His family history was unimportant. He began having pains in and around the left ear, January 10, 1939. His temperature varied from normal to 103 degrees for several days. Swelling and redness behind the left ear began three days after the pain. The drum was only slightly congested, and

at no time before the operation was there a discharge from the ear.

I was very reluctant to make a diagnosis of mastoiditis without more changes in the drum, and discharges and he was treated with heat and aspirin for ten days from the beginning of the pain. A paracentesis for drainage was not indicated since there was apparently no disease other than of the mastoid antrum and cells. From the beginning of his sickness the swelling, pain, and redness increased—one some days less than on others. The swelling behind the ear was that of a typical mastoiditis—the external ear standing out from the head, and the skin being very red. At this time an X-ray presented evidence of mastoid disease as compared with the right or normal side.

Only a small amount of pus found at operation and there was as far as could be determined, no necrosis of the bone, the disease evidently being confined to the mucous membrane. After operation the boy was comfortable and ran a temperature of 100 to 101 degrees for six days. He had no more pain and no longer looked sick, as he had before. On the eighth day he was sent home from the hospital after two days of normal temperature. He had a normal temperature for eight successive days at which time his fever returned and ranged from 100 degrees to 104 degrees, but did not fluctuate much from day to day. Sulfanilamide (24 grains per day) was given thinking there might be a flaring up of the infection somewhere, possibly in the blood stream, although he lacked symptoms of blood stream infection.

It was singular that the boy had no symptoms after the operation except fever. He ate well; he slept well; he felt well. There was no rigidity of the neck; there were no chills. There was no glandular enlargement, and reflexes and eye grounds were normal. The urine was negative, and the chest examination was negative. The throat was slightly red but not sore. A blood test was negative for typhoid, unlulant fever, and blood stream infection. He had a white count of 15,000—hemoglobin fifty-five per cent.

The case was talked over with several doctors, and an internist examined him carefully, but no one seemed to know why the fever continued. It was finally suggested to discontinue the sulfanilamide to see what would happen. This was done and the temperature became normal in sixteen hours, and did not rise again. There was no cyanosis at any time during sulfanilamide administration. In fact, he was sick without a symptom after the temperature went to normal the sixth day after the operation. This seems to have been a mastoid infection without middle ear involvement—a rare case.

This could not have been mistaken for a simple cellulitis of the mastoid region due to the fact that the x-ray plate definitely showed a change in the region as compared to the right, and pus was found in the antrum.

It is not known why his temperature rose after being normal for eight days following the operation although possibly a mild upper respiratory infection, commonly called influenza, was responsible. A good many of these infections were present in the city at that time. Also the possibility that the continued administration of sulfanilamide was responsible has been considered, especially since the fever came down to normal and remained so sixteen hours after sulfanilamide was discontinued.

TUBERCULOSIS CONTROL

The following extracts from an article by A. E. Jaffin, M.D., Jersey City, New Jersey, which appeared in the February issue of the Journal of the Medical Society of New Jersey, were presented in the July 1939 issue of the pamphlet, Tuberculosis Abstracts, issued monthly by the National Tuberculosis Association.

CASE-FINDINGS IN PUBLIC SCHOOLS

1. Question—How valid is the tuberculin test? May we assure parents that the positive or the negative reaction is absolutely correct?

Answer—The tuberculin test is one of the most reliable tests that we have for determining whether or not tubercle bacilli have at some time entered the body. If positive, it does not necessarily indicate the presence of tuberculosis, the degree of infection, nor the extent of damage done, if any.

For all practical purposes, exceptions to this statement may be ignored. They should not cause worry to parents.

2. Question—Which grades should be tested?

Answer—The ideal plan would be to test children of all grades and ages.

First Grade Pupils—In this group one is likely to find so small a number of infections as hardly to make the effort worth while on a very large scale. On the other hand, experience has shown that very young children with positive tuberculin reactions will serve as leads to a large number of open cases of tuberculosis that were active sources of infection.

Kindergarten—The same may be said of this group.

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High School—The high school age is receiving special attention for several reasons. First, because of the high morbidity and mortality rate known to exist between the ages of fifteen and twenty-five. Secondly, because in the average high school a large percentage of this important age group is available under ideally-controlled conditions. More cases of tuberculous infections are likely to be found in this age than in the lower grades.

3. Question—When is re-testing advisable?

Answer—All tuberculin-negative students should be re-tested at least once a year. All tuberculin-positive students should be re-x-rayed at least once a year, unless something abnormal is found, when the frequency of re-x-raying will depend upon the particular circumstances in each case.

4. Question—Is the Mantoux test so definitely superior to other tests that the question of choice may be ignored?

Answer—The Mantoux test is definitely superior to other tests because:

(1.) It is twice as sensitive as the scratch test of Von Pirquet.

(2.) It is an exact quantitative test.

(3.) The response when positive is more definite, and more prompt than in all other tests.

However, as a second choice, especially in the face of obection to the "needle," the Patch test may be used. The following are the objections to the Patch test:

(1.) It must be kept dry.

(2.) It must not be interfered with by the child.

(3.) Frequently when examined at the end of forty-eight hours, it may be negative, and require four days for a reading.

(4.) Under the best of circumstances it is at least five per cent less reliable than the Mantoux test.

(5.) The greater cost of each test would also become a financial problem if planned for a large number.

5. Question—What is the significance of different degrees of reaction?

Answer—Different degrees of reaction have no significance beyond the fact that they indicate different degrees of sensitivity. This has no bearing upon the question of the amount of infection or disease, and need not concern school administrators or even school physicians. It is better not to confuse the minds of parents with any attempts to interpret degrees of reaction.

6. Question—Should all positive reactors be x-rayed? Are there indications to warrant x-raying of negative reactors?

Answer—All positive reactors should, without exception, be x-rayed.

With reference to negative reactors, an x-ray is not necessary to exclude tuberculosis; but it is frequently advisable for certain special reasons, such as malnutrition, suspicion of heart disease, chest deformity, or recent non-tuberculous lung infections such as pneumonia, or the presence of symptoms of chronic bronchitis or pulmonary disease of non-tuberculous character.

7. Question on the accuracy of the paper x-ray film, is answered by defining the limitations of paper film, appraising its advantages and stating that paper films are quite satisfactory in the "sifting" process or screening out of abnormalities.

8. Question—Is the celluloid film infallible?

Answer—No. There are lesions in the lung so small and so translucent to the ray that they may not be demonstrable in any films.

9. Question—Assuming a positive reaction to the Mantoux, and a negative reading of a paper film, what should be told parents?

Answer—A positive Mantoux reaction, by itself, does not indicate that a person has tuberculosis. "If the tuberculin test is positive (red and swollen), it means only that tuberculosis germs have at some time entered the body. It does not tell how many there are, or if any damage has been done. It should not cause worry to parents.

"If the test is positive, the child's chest should be x-rayed to be certain that no harm is being done in the lungs. An x-ray examination should also be made of every member of the household to learn if the child is being exposed to an open case of tuberculosis. Frequently this may reveal other cases of tuberculosis before the victim is at all aware of the disease. If no one in the family has the disease, search should be made among the child's playmates or others with whom he comes in close contact. It is perfectly safe for a child with a positive reaction to mingle with other children,—for unless there are tubercle bacilli in his sputum, he cannot pass them to others. Tuberculosis often exists in a concealed form in unsuspecting persons, and it is important to make the discovery in order to prevent further spread of the disease."

The parents should also be advised that the tuberculin-positive student should be x-rayed regularly at least once a year so as to detect any evidence of reinfection as early as possible. If the tuberculin test is negative, no x-rays are necessary until a subsequent tuberculin test proves to be positive.

10. Question—Will you outline briefly the follow-up procedure for the average school district?

Answer—After a tuberculosis survey, the parents

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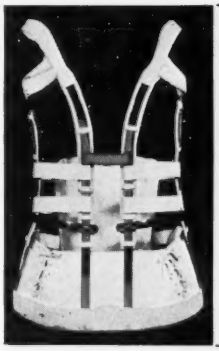

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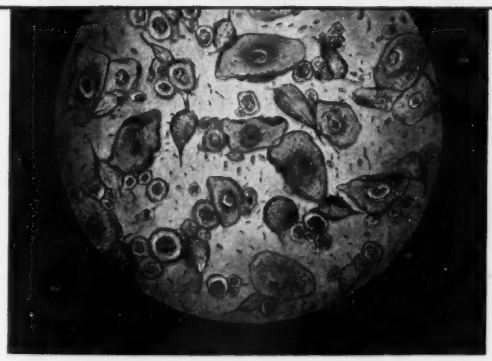

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are advised in a general way as to the results, and instructed to see their family physician for further explanation of the same.

Parents receiving reports to the effect that the Mantoux test was negative are advised of the importance of having the children re-tested annually by their own doctor, as long as they are negative.

In the case of the child who had a positive Mantoux with a negative x-ray, the parents are advised to have the child x-rayed, at least once a year thereafter through their own physician. They are also advised to have all other members of the household x-rayed, and all children under fifteen Mantoux tested.

In the case of those children in whom the x-ray showed some abnormality, the parents are particularly urged to take the report of the findings to their family physician at once. He is to be further informed of the desirability of communicating personally with those conducting the survey, who should endeavor to cooperate with him to the fullest extent on behalf of his patient. For those who cannot afford private service, the facilities of the tuberculosis clinics should be made available.

With reference to the schools, plans are formulated for continuing these surveys so as to test all new admissions each spring, as well as those previously tuberculin-negative.

It is advised that no child should be excluded from school until the x-ray reveals findings that would warrant it and no type of active case, communicable or not, should remain in school—all active cases require treatment.

SUPPLEMENTARY MEASURES IN THE TREATMENT OF PNEUMONIA

(Continued from Page 293)

Opinion still differs as to the merits of digitalis in this disease. Certainly its use should be continued for those individuals who required it prior to the onset of pneumonia. Insofar as the remaining cases are concerned, it is significant to note that the routine use of digitalis has been abandoned on a large ward in New York City where hundreds of cases of pneumonia are treated each year.

It has been the time-honored custom to give whiskey to the pneumonia patient, especially to those accustomed to its use and to those with delirium tremens. It is probable that in such cases small doses do no harm, but more reliable sedatives may well be substituted for it. Pickerell[3] has shown in experimental animals that alcoholic intoxication destroys resistance to pneumococcal infections by profoundly inhibiting the respiratory vascular response.

Sedatives which will assure the restless patient an adequate amount of sleep are invaluable. No attempt can be made here to list all the drugs employed for this purpose. It is realized that every physician has a drug or a combination of drugs which in his experience have given good results. A few are suggested because they have been found especially dependable. Avertin given by rectum in doses of 0.6 to 0.8 grams per kilo is very effective and is employed on the wards at Harlem Hospital for controlling delirium tremens. For the milder grades of restlessness, a combination of chloral hydrate gr. XX with sodium bromide gr. LX will frequently bring unbroken sleep for several hours. Paraldehyde drams IV by mouth has also been successfully employed, but may be objectionable because of its odor and taste. Morphine should not be used in delirium, nor should chloral hydrate be used in alcoholics.

There remains one more fundamental measure to be considered in the treatment of pneumonia, and that is the management of complications. Although they are not present in every case, they are significant in that whenever they do occur they lessen the chances of recovery. Complications which are most commonly encountered and most serious in their effects include pulmonary edema, empyema, pneumococcus meningitis, and delirium. Pulmonary edema, however mild, is a symptom of grave importance because its extensive development is usually fatal. As seen in the pneumonias, it is probably a combination of inflammatory and mechanical edema, a response to the inflammation set up by the invading organisms and to the accumulation of excess blood in the pulmonary circulation as a result of failure of the right ventricle. At the same time, serum leaks through the capillary walls into the alveoli. The resulting cyanosis indicates interference with the mechanism employed in respiration and consequent occurrence of anoxia. Unless the anoxia is relieved promptly, death may be expected. Before the condition becomes very severe, temporary relief may be given by administration of oxygen under pressure and by intravenous injection of fifty to 100 cc. of a fifty percent sucrose solution. These same procedures are carried out in severe cases but are likely to be of no avail.

Empyema is to be suspected when the patient's temperature either fails to return to normal after adequate specific therapy, or rises again after crisis or after lysis. Physical examination will frequently reveal diminished or absent breath sounds, absence of vocal fremitus, and flatness over the collection of fluid. A massive empyema will cause a shift of the mediastinum and trachea to the opposite side. As a differential diagnostic point, atelectasis will likewise

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In view of the favorable reception accorded the etiologic classification in the 1937 edition of "INTRODUCTION TO DERMATOLOGY" and the tendency nowadays to inquire "What is going on?" rather than "What name is applicable to this manifestation?" the material has been arranged in a fashion radically different from the arrangement of the ninth edition.

There have been added a number of colored plates and 300 new illustrations. By condensation of type and more efficient use of page space, 50 per cent increase in textual matter and approximately 3,000 additional bibliographic entries have been included. Descriptions of all significant entities, syndromes, and concepts, and of many exotic, unusual, and even exceptional dermatoses have been incorporated. The authors have not hesitated to give their opinion and ideas, particularly regarding treatment. In some cases these are original, as in the treatment of Calcinosis Universalis, Urticaria Pigmentosa, and Pityriases Rosea, in the etiology of Infantile Mycotic Eczema as a birth canal infection, and in the description of Keratoses and early Carcinomas.

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cause diminished or absent breath sounds, absence of vocal fremitus and flatness but if massive enough, will cause displacement of the mediastinum and trachea toward the affected side. Collections of fluid so small that their location by physical examination is difficult or impossible may nevertheless be the cause of a constantly elevated temperature. Careful x-ray examination will usually reveal the position of these small pockets of pus. If possible, they should be drained by aspiration, repeated at intervals if necessary. However, if the pus is too thick for aspiration, or inaccessible to the needle, the possibility of thoracotomy should be considered.

Until the advent of sulfapyridine therapy, pneumococcus meningitis was usually fatal. A goodly number of recoveries have recently been reported following the use of sulfapyridine.

Delirium is a grave omen and its advent is cause for real concern. Its seriousness is indicated by the fact that in a series[2] of 106 delirious cases of type I pneumonia the mortality was 42.6 percent. Anoxia, insomnia, and unrelieved restlessness are factors which contribute to the development of delirium. Sedatives are generally required as auxiliary treatment. Of these the barbiturates, chloral hydrate, avertin, and paraldehyde are preferable. Oxygen for the relief of anoxia is also indicated. Morphine should not be used in delirium.

In summary, pneumonia remains a serious and frequently fatal disease, which will often tax to the utmost the resources of the attending physician. Recent articles on pneumonia have dealt almost entirely with serum therapy or the new drug treatment. These are highly important and every physician should become familiar with the latest developments concerning them. However, in his zeal for bombarding the pneumococcus with antibodies and applying chemical brakes to its growth, the physician must never forget that he is dealing with a sick human being. He must realize too, that for many patients these biological and chemical weapons of defense can not be used. For these patients—for all pneumonia patients—adequate nursing care, proper diet, administration of oxygen, judicious use of drugs, and correct management of complications are likely to remain indispensable factors in the treatment of the pneumonias.

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NEWS NOTES

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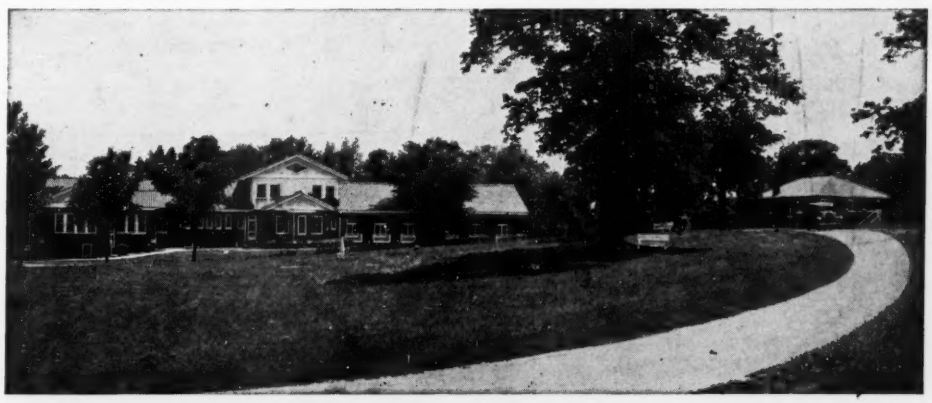

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KANSAS STATE BOARD OF HEALTH MEETING

The Kansas State Board of Health met in the office of the secretary, F. P. Helm, M.D., June 27. All members of the board were present, including: George I. Thacher, M.D., Waterville; J. T. Reid, M.D., Iola; H. L. Aldrich, M.D., Caney; R. W. Urie, M.D., Parsons; R. T. Nichols, M.D., Hiawatha; J. F. Gsell, M.D., Wichita; W. C. Lathrop, M.D., Norton; G. A. Leslie, M.D., McDonald, J. L. Lattimore, M.D., Topeka; William E. Scott, Attorney, Kansas City. Doctor Thacher was re-elected president of the board.

The board members expressed their deep appreciation of Doctor Aldrich's twenty years of faithful service as a member of the board. The secretary was also requested to send a letter to Thomas I. Dalton, assistant chief food and

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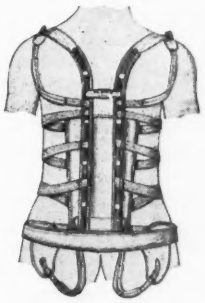

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drugs inspector, in grateful acknowledgement of his twenty years of loyal service to the state health department.

Former paper service regulations were rescinded and new ones passed, stipulating either sanitary methods of washing and sterilizing utensils and dishes used in serving food and drinks, or the use of paper service.

The need of establishing standardized tuberculosis clinics in the state was brought to the attention of the board, and the following resolution was passed:

"WHEREAS, The Kansas State Board of Health, by legislative action, is charged with the prevention of tuberculosis, and is represented in this work by its division of tuberculosis control; and

"WHEREAS, The State Board of Health recognizes the value of modern clinic service conducted for purposes of diagnosis and case-finding as an aid in the eradication of tuberculosis;

"BE IT RESOLVED that the State Board of Health directs the division of tuberculosis control to work out standards for diagnostic tuberculosis clinics, with and acceptable to the committee on tuberculosis control of the Kansas Medical Society, and to present such standards to the State Board of Health for final approval, at a future meeting."

Several other matters pertaining to public health functions in Kansas were considered.

CANCER COMMITTEE MEETING

A meeting of the Society Committee for Control of Cancer was held in Topeka on July 6. Minutes of the meeting will be published in the next issue of the Journal.

CONGRESS

Two measures of particular interest and importance to the medical profession are pending in Congress. One, the Wagner bill, S. 1620, which was described in the last issue of the Journal, still remains unacted upon, in the Senate Committee on Education and Labor. The other measure an amendment presented by Senator Wagner to House Resolution 6635, is now pending in the Senate Committee on Finance. The suggested amendment provides that the Federal Social Security Board shall have the power to provide certain medical and institutional services to certain prescribed persons.

All members are urged to familiarize themselves with the contents of these proposals and to communicate their sentiments to Senator Arthur Capper, Senator Clyde Reed, and their Congressman. A particularly interesting and informative description of the Wagner act is to be found in the report of the hearings on the act published in the June 10, 17, and 24 issues of the Journal of the American Medical Association.

EXECUTIVE COMMITTEE

A meeting of the Executive Committee of Kansas Womans Field Army for the Control of Cancer was held in Topeka on June 29. Dr. C. C. Nesselrode of Kansas City, and Dr. Howard Snyder of Winfield, were representatives of the Society at the meeting. Dr. Frank Rector of Evanston, Illinois, field representative for the American Society for Control of Cancer also attended.

Mrs. Donald Muir of Anthony, State Commander of the Kansas Women's Field Army, presented the next year's contemplated program of that organization for approval.

NARCOTICS

Judge Richard J. Hopkins of the Federal District Court handed down a decree in the case of Kansas State Osteopathic Association vs. William H. Burke, Collector of Internal Revenue on June 26. The decree which held that osteopaths are entitled to register for narcotic stamps in Kansas is as follows:

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF KANSAS

The Kansas State Osteopathic Association incorporated, K. A. Bush, Dale McCoy, L. O. Martin, Raymond L. DeLong, R. Raymond Wallace, Karl M. Pearson, Fred E. Hastings, for themselves individually, and as officers of the said The Kansas State Osteopathic Association, Incorporated,

Plaintiffs,

vs.

William H. Burke, as Collector of Internal Revenue of the United States of America in the State of Kansas,

Defendant.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This is an action to enjoin the defendant William H. Burke as the Collector of Internal Revenue of the United States of America in the State of Kansas, and his aids, servants and employees from refusing to register and issue narcotic licenses and stamps to osteopathic physicians duly licensed to practice osteopathy within the State of Kansas, on the ground that the laws of the state do not permit osteopathic physicians to use narcotic drugs. The action was tried to the Court, partially upon an agreed statement of facts and partially upon oral testimony. Arguments were made, briefs and authorities filed by the respective parties, and under the stipulation of facts, the case stands submitted to the Court for determination. I find the facts as follows:

FINDINGS OF FACT

1. The Kansas State Osteopathic Association is a corporation duly organized and existing under and by virtue of the laws of the State of Kansas. K. A. Bush, Dale McCoy, L. O. Martin, Raymond L. DeLong, R. Raymond Wallace, Karl M. Pearson and Fred E. Hastings are the officers and trustees of such corporation and as individuals are practicing osteopathic physicians within the State of Kansas.

2. William H. Burke is the Collector of Internal Revenue of the United States of America in the State of Kansas and as such is the duly authorized agent of the United States of America to register physicians and other practitioners in the State of Kansas authorized to use narcotic drugs in their professional practice. He has refused, is refusing and unless enjoined, will continue to refuse to register osteopathic physicians and grant them permits and stamps for the use of narcotic drugs, including the individual plaintiffs herein, for the reason that he contends that osteopatic physicians are not authorized under the laws of the State of Kansas to administer or use narcotic drugs in their professional practice.

3. Osteopathic physicians practicing their profession in the State of Kansas have been receiving permits and stamps for the use of narcotics since the passage of the Harrison Narcotic Act in 1915.

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4. Osteopathic colleges of good repute during the year 1913 and prior thereto, taught and practiced the use of narcotics. Students in osteopathic colleges were taught the chemistry and toxicology of narcotic drugs. They were taught the effect, dosage, and use of narcotics.

5. The use of narcotics is and was prior to 1931, a necessary part of the practice of osteopathy and was taught and practiced in osteopathic colleges of good repute during the year 1913 and prior thereto as such. Osteopathic physicians could not carry on the practice of osteopathy as taught and practiced in osteopathic colleges of good repute without the use of narcotics.

6. Narcotic drugs are used by those practicing the healing art largely for the relief of severe pain, to overcome restlessness, apprehension, and to prevent the effects of systematic strain and shock, and not as a direct remedy or cure for any disease or bodily ailment.

7. Narcotic drugs are used by osteopathic physicians for their palliative effect, either to relieve the patient from unbearable or unnecessary suffering or to release the tension caused by pain so that osteopathic treatment can be applied. Narcotic drugs are not used by the osteopathic profession as a remedy or cure for any disease or bodily ailment.

CONCLUSIONS OF LAW

From the above and foregoing facts, I conclude that:

1. The Harrison Narcotic Act, 26 U.S.C.A. 1383 and 1384 provides for the registration and payment of a fee by physicians, dentists, veterinary surgeons and other practitioners lawfully entitled to distribute, dispense, give away or administer any narcotic drugs to patients upon whom they, in the course of their professional practice, are in attendance. Whether or not osteopathic physicians are lawfully entitled to distribute, dispense, give away or administer narcotic drugs to patients upon whom they in the course of their professional practice are in attendance, is to be determined by the laws of the state in which they are practicing their profession.

2. The General Statutes of Kansas, 1935, Section 65-1201 was passed in 1913 and covers the practice rights of osteopathic physicians. It provides in part as follows:

> "Any person not now a registered osteopathic physician of this state, before engaging in the practice of osteopathys in this state shall make application to the board of osteopathic examination and registration, on a form prescribed by the board, for a certificate to practice osteopathy ****. If such examination is passed in a manner satisfactory to the board, then the board shall issue to said applicant a certificate granting him the right to practice osteopathy in the State of Kansas as taught and practiced in the legally incorporated colleges of osteopathy in good repute."

What is included in the practice of osteopathy as taught and practiced in the legally incorporated colleges of osteopathy of good repute in the year 1913, is a question of fact.

3. The use of narcotics was a part of the practice of osteopathy in the year 1913 as taught and practiced in the legally incorporated colleges of osteopathy of good repute within the meaning of the Osteopathic Practice Act of the State of Kansas.

4. Under the laws of the State of Kansas, osteopathic physicians are lawfully entitled to distribute, dispense or administer narcotic drugs as taught and practiced in the legally incorporated colleges of good repute during the year 1913 and prior thereto.

5. William H. Burke as Collector of Internal Revenue of the United States of America in the State of Kansas, his aids, servants and employees, should be permanently enjoined from refusing to register and issue narcotic licenses and stamps to osteopathic physicians and the individual plaintiffs herein, on the ground that they are not lawfully entitled to distribute, dispense, give away or administer narcotic drugs to patients upon whom they, in the course of their professional practice, are in attendance.

It is probable that Mr. S. S. Alexander, District Attorney, for the Collector of Internal Revenue will appeal the case to the United States District Court of Appeals. In the meantime Kansas osteopaths will be able to secure narcotic stamps inasmuch as the action of the Federal District Court overrules the present ruling of the Narcotic Division that osteopaths are not entitled to register in Kansas.

COUNTY SOCIETIES

The Butler-Greenwood County Medical Society met June 9 at the Susan B. Allen Hospital, El Dorado. Dr. John Kleinheksel, of Wichita, discussed the etiology, diagnosis and treatment of diabetes.

The Clay County Medical Society held a meeting June 14 at the Clay Center Municipal Hospital. The main topic of the meeting was a discussion of county medical society public health advertising plans. Visitors attending were: Drs. B. A. Nelson, of Manhattan; G. A. Attwood, of Randolph; Clifford L. VanPelt, of Paola; D. A. Bitzer, of Washington; J. M. Porter, Secretary of The Kansas Medical Society, of Concordia; D. I. Marker of Manhattan; Forrest L. Loveland, President Elect of The Kansas Medical Society, of Topeka; Mr. Clarence G. Munns, of Topeka; and Mr. Ray Breitweiser, Editor of the Clay Center Dispatch, of Clay Center.

Lyon County Medical Society held a meeting June 6, at the Newman Memorial Hospital, Emporia. Dr. G. M. Tice, University of Kansas School of Medicine, presented a paper "Use of X-ray in Endocrinology," and Dr. E. H. Hashinger also of the University of Kansas School of Medicine, presented a paper "Recent Advances in Endocrinology."

The McPherson County Medical Society held a dinner meeting on June 14 at the Hotel McCourt, in McPherson. Guest speakers were: Dr. Ralph S. Casford, Kansas City, who spoke on "Heart Disease"; and Dr. C. C. Wilson, Kansas City, Missouri, who spoke on "Operative and Non-operative Rectal Troubles."

The Southeast Kansas Medical Society held a meeting June 21, in the Hotel Stillwell, Pittsburg. Dr. Lawrence P. Engel and Dr. Ferdinand C. Helwig, both of the University of Kansas School of Medicine, presented a surgical pathological symposium. Dr. Clarence W. Erickson, of Pittsburg, also presented a paper.

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The Saline County Medical Society met June 8, at the cafe Casa Bonita, in Salina. Dr. Roy Croson, of Clay Center, gave a paper on "Acute Intestinal Obstruction." Discussion of the paper was opened by Dr. L. S. Nelson, of Salina. Dr. W. R. Dillingham, of Salina, presented a paper on the "Use of Prolonged Anesthesia in Rectal Cases." Dr. George Seitz, of Salina, opened the discussion on the latter paper.

The Wilson County Medical Society and the Kansas Crippled Children's Commission sponsored a free orthopaedic clinic at Neodesha, on June 9. Dr. C. B. Francisco, of Kansas City, and Dr. A. E. Bence, of Wichita, assisted in the clinic.

The Washington County Medical Society met June 13 for a dinner meeting at the Hotel Washington. Dr. Roy Croson, of Clay Center, was the guest speaker.

MEMBERS

Dr. M. E. Pusitz of Topeka, was a guest speaker at the meeting of the American Physiotherapy Association in Denver, Colorado, June 25-30. His subjects were: "Cerebral Palsy—General Considerations" and "Physiotherapeutic Regime in Cerebral Palsy."

Dr. H. F. Craig, Protection, has recently been appointed county health officer of Comanche county.

The National Board of Oto-Laryngology recently announced the certification of Dr. W. B. Granger, Emporia, as a diplomate of that Board.

Dr. G. S. Ortman, formerly of Mankato, has moved to Solomon. He will practice in the office formerly occupied by Dr. Ralph Loudon who has moved to Nebraska.

Dr. A. E. Reed has been named as physician for the Atchison, Topeka and Santa Fe Railroad, at Larned, to succeed the late Dr. C. H. Ewing.

Dr. H. G. Schaumloffel, formerly of Colony, has moved to Williamsburg, where he will open an office. Williamsburg has been without a physician since the death of Dr. G. K. Janes, in February.

Dr. C. O. Anderson, Dr. E. N. Robertson and Dr. E. N. Robertson, Jr., all of Concordia, were recently elected to the St. Joseph Hospital staff at Concordia.

Dr. Robert H. Riedel, director of venereal disease control for the state health department, has returned to Topeka, from Harvard, where he completed nine months postgraduate work.

DEATH NOTICES

Dr. Henry Jackson Deaver, 73 years of age, died at Sabetha, June 19. Dr. Deaver was born April 15, 1866, at Chapel Hill, Perry county, Ohio, and graduated from Starling Medical College, Columbus, Ohio, in 1892, at which time he came to Sabetha. He also practiced medicine in Goff and Fairview for a few years, later returning to Sabetha. He was a member of the Brown County Medical Society.

Dr. Hal H. Hazlett, 65 years of age, died in Topeka on June 4. Dr. Hazlett was born April 8, 1874, in Newark, Ohio. He received his medical education from the Barnes Medical College, St. Louis, Missouri. He served in Company F, Thirty-second Infantry of the United States Army, during the Spanish-American War. He was a member of the Christ's Hospital staff more than thirty years and a member of the Shawnee County Medical Society.

Dr. Ralph Harold Hertzler, 52 years of age, died of coronary occlusion in Newton, March 30. Dr. Hertzler was born at Burlington, Iowa, June 14, 1886. He received his preparatory schooling in Iowa, and his medical education at Northwestern University Medical school, Chicago, Illinois. He was among the first Newton men to enlist for over-sea service in the World War, where he was commissioned a captain in the medical corps. He was a member of the Bethel Clinic of Newton and the Harvey County Medical Society.

Dr. Alonzo Woodford Little, 60 years of age, of Kansas City, died June 8, in the Veterans' Administration Hospital at Wadsworth, Kansas. Dr. Little received his medical education from the University Medical College of Kansas City, Missouri. He served in the United States Navy during the World War. He was a member of the Wyandotte County Medical Society.

Dr. William Frederic Schroeder, 48 years of age, was fatally injured in an automobile accident June 12, near Newton. Dr. Schroeder, who was Harvey county health officer at the time of his death, was born at Butterfield, Minnesota, September 6, 1890. He received his medical education at Rush Medical College, Chicago, Illinois, and located in Goessel, Kansas, following his graduation. He later moved to Newton, where he practiced until his death. He was a member of the Harvey County Medical Society.

MEDICAL BOARD

The Kansas Board of Medical Registration and Examination announces the list of doctors for June 1939, who have been granted licenses to practice medicine and surgery in Kansas.

Eighty-one took the examination, but four failed to obtain the required grade, which leaves a total of seventy-seven who will receive certificates by examination. There were nine applicants for license by reciprocity, and all were favorably passed upon by the Board, making a total of eighty-six who will receive certificates. The list is as follows:

Anderson, Raymond B., Anderson, Robert C., Andreson, Clarence W., Asling, Clarence W., Basham, George L., Bennett, James Dale, Betz, John S., Boody, Robert J., Bux, Robert J., Campion, Woodrow N., Clark, Ray A., Cramer, Guy W., Cushing, Vernon D., Cziraky, Anton., Davis, Christopher G., Day, Hughes W., DeMott, Jack D., Dienger, Bernard C., Donnelly, Bernard A., Dorsey, Elizabeth., Eitzen, Oliver., Filkin, Lawrence E., Ford, Frederick L., Forman, Louis H., James, Frank H., Johnson, Elmer F., Kendig, Thomas A., Ladd, Arthur C., Lane, Henry W., Lee, Carleton H., Lozoff, Milton., Maclean, John A., Messenheimer, Myron G., Meyer, Donald D., Milligan, Paul R.

Millikan, Clark H., Mininger, Edward P., Moon, Roger A., Morrow, Raymond L., McCool, Stanton A., McKee, Leo F., Nash, Francis J., Nothnagel, Arnold F., Oleen, George G., O'Neill, Francis E., Pendleton, Raymond L., Petterson, Cecil E., Pruitt, Raymond D., Gage, Maurice., Garber, Pauline., Graves, Louis C., Greer, Richard H., Haas,

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☐ Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245—"Pharmacology of Inflammation: III. Influence of Hygroscopic Agents on Irritation From Cigarette Smoke."

☐ N. Y. State Jour. Med. 1935, 35-No. 11,590—"Irritating Properties of Cigarette Smoke as Influenced by Hygroscopic Agents."

☐ Laryngoscope, 1935, XLV, No. 2, 149-154—"Some Clinical Observations on the Influence of Certain Hygroscopic Agents in Cigarettes."

☐ Laryngoscope, 1937, XLVII, 58-60—"Further Clinical Observations on the Influence of Hygroscopic Agents in Cigarettes."

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KAN.

Louis R., Hagan, Francis J., Haigler, James P., Herman, Allen I., Hood, Thomas R., Hughes, Raymond H., Hunter, Kenneth R., Thompson, Mary E., Thompson, Burl V., Thorpe, George L., Tracy, Herbert A., Trees, Clyde B., Turner, John W., Underwood, Dick H., Voorhees, Gordon S., Reid, James A., Robison, Corbin E., Schneider, Robert W., Sereres, Edgar P., Shanklin, John H., Shircliff, Edward E., Shonyo, Elwyn S., Statland, Harry., Stotts, Charles S., Swann, Clair L., Terry, Jack T., Wade, Frederick E., Wakeman, Everal M., Walters, Byron W., Waxse, Isadore J., Weber, Clarence J., Wieseler, Rudolph J., Willoughby, Jean B., Woods, Harold V., Wyatt, Lisle M.

The license of Dr. John H. Clark, Coffeyville, Kansas, was revoked on a felony charge.

The Board has authorized a 1939-1940 roster, which will be published late this fall.

The examination subjects were reassigned to the various members of the Board.

Dr. M. C. Ruble was unanimously elected to the office of President of the Board for the ensuing year.

The next regular meeting of the Board will be held at the Kansan Hotel, Topeka, December 12-13, 1939.

F. S. A. PLANS

The Society is preparing a survey of Farm Security Administration plans now operating in the state. It is planned that the survey, which will include a description of the differences of the various F. S. A. contracts in the state and a suggested contract, will be bulletinized to the county medical societies in the near future.

INDIGENT CARE

A considerable number of county medical societies have recently renewed or inaugurated indigent medical care plans. Approximately sixty-five counties in the state now have free choice plans operated by their county medical societies.

The Society is investigating thru the Kansas State Board of Social Welfare, possibilities for obtaining Federal and State financial participation in indigent medical plans. In the event several recent Federal rulings make this assistance available, it is possible that present county expenditures for indigent medical care may be considerably increased.

ANNOUNCEMENTS

Michael Reese Hospital, 29th and Ellis Avenue, Chicago, Illinois, announces a graduate course in Electrocardiography, to be given by Dr. Louis Katz. The course will last two weeks, from August 21 to September 2. Dr. Katz is director of Cardiovascular Research of that hospital.

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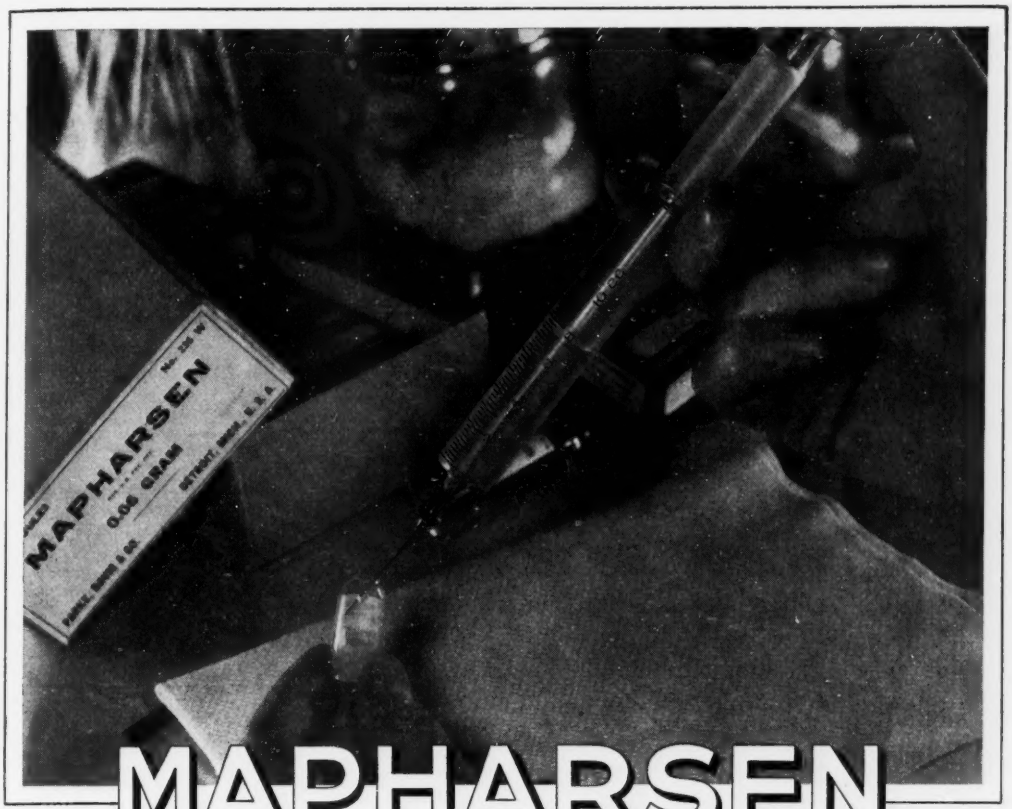

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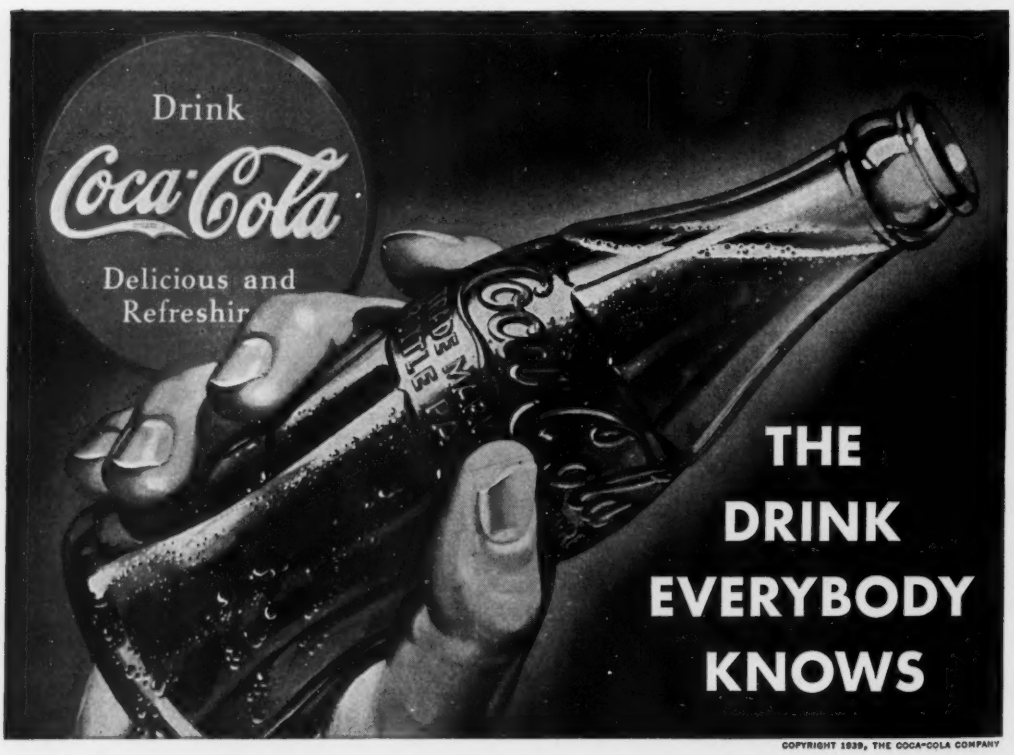

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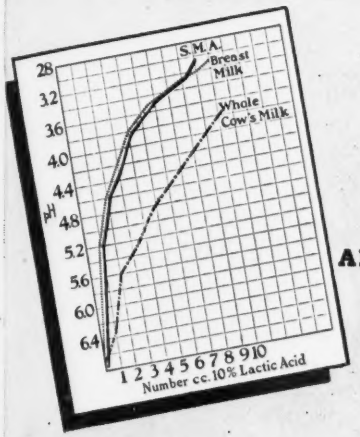
Specific Gravity	1.032	1.032
Caloric Value: —per 100 c. c.	68.0	68.0
—per ounce	20.0	20.0



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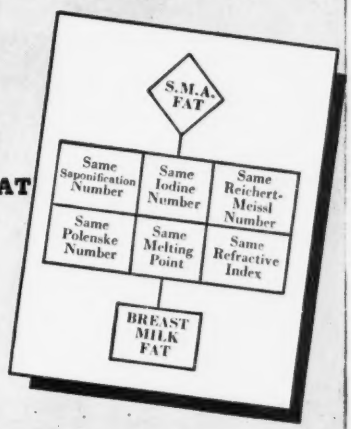

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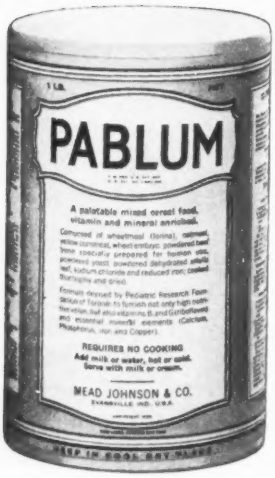
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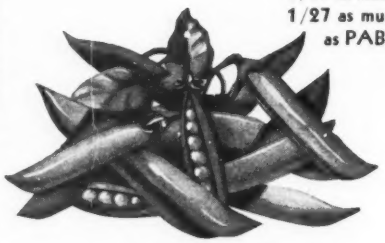
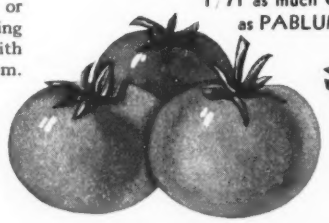
Peas	0.50	8.0
Spinach	1.13	21.8
String Beans	0.27	14.2
Tomatoes	0.12	3.1

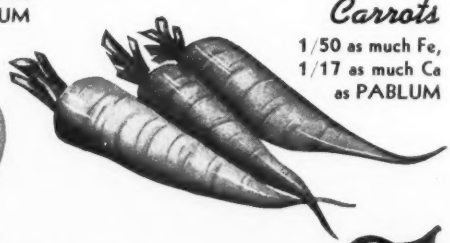
Peas
1/17 as much Fe,
1/27 as much Ca
as PABLUM



Tomatoes
1/70 as much Fe,
1/71 as much Ca
as PABLUM



Carrots
1/50 as much Fe,
1/17 as much Ca
as PABLUM



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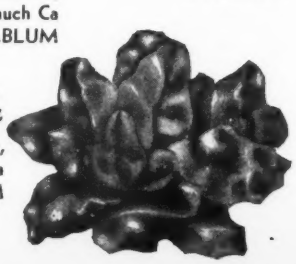
1/15 as much Ca
as PABLUM

Beets
1/12 as much Fe,
1/32 as much Ca
as PABLUM

Spinach
1/12 as much Fe,
1/10 as much Ca
as PABLUM



Pablum consists of wheatmeal (farina), oatmeal, wheat embryo, cornmeal, beef bone, brewers yeast, alfalfa leaf, sodium chloride and reduced iron

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